FRAMEWORK FOR STATE EVALUATION
OF CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: _____IDAHO_____
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____ _____

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

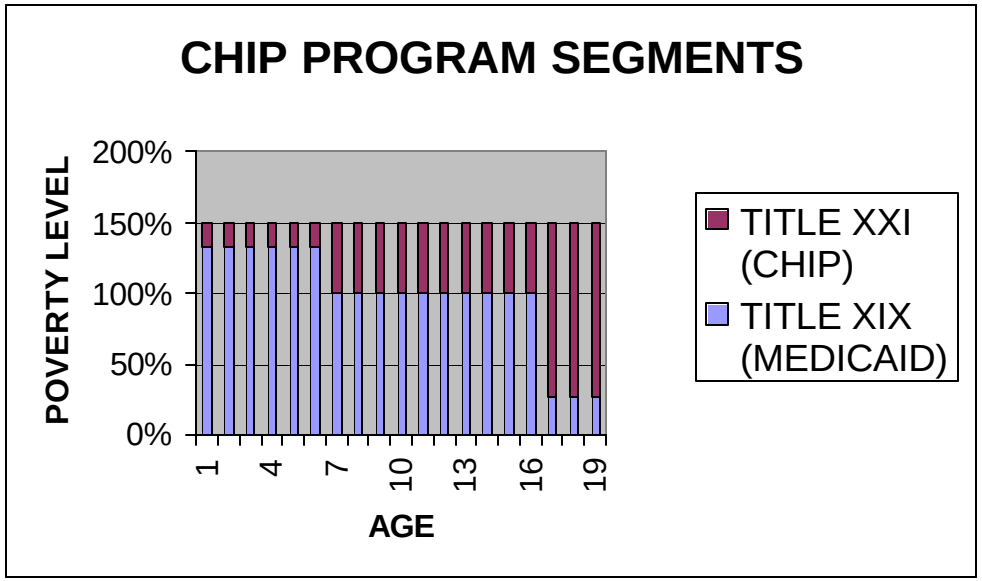
Introduction:

The Idaho Children's Health Insurance Program (CHIP) is administered by the Idaho Department of Health and Welfare (DHW). Successful implementation of the CHIP program is one of Idaho Governor Dirk Kempthorne's and DHW Director Karl Kurtz's major priorities.

DHW is an umbrella human services organization with direct responsibility for child protection, child abuse prevention, health, Medicaid, family cash and other subsidy income supports, developmental services, and mental health and substance abuse services. DHW staff includes line personnel in each of these areas who have daily contact with children and families as well as regular contact with community leaders.

DHW's vision statement is: ***" to provide leadership for development and implementation of a sustainable integrated health and human service system."*** The successful implementation of CHIP has provided DHW with the opportunity to operationalize this vision by developing creative strategies to encourage coordination of outreach and enrollment activities across its divisions and by establishing successful partnerships with interested stakeholders external to the department to ensure sustainable outreach activities and ongoing provision of quality health care services to children.

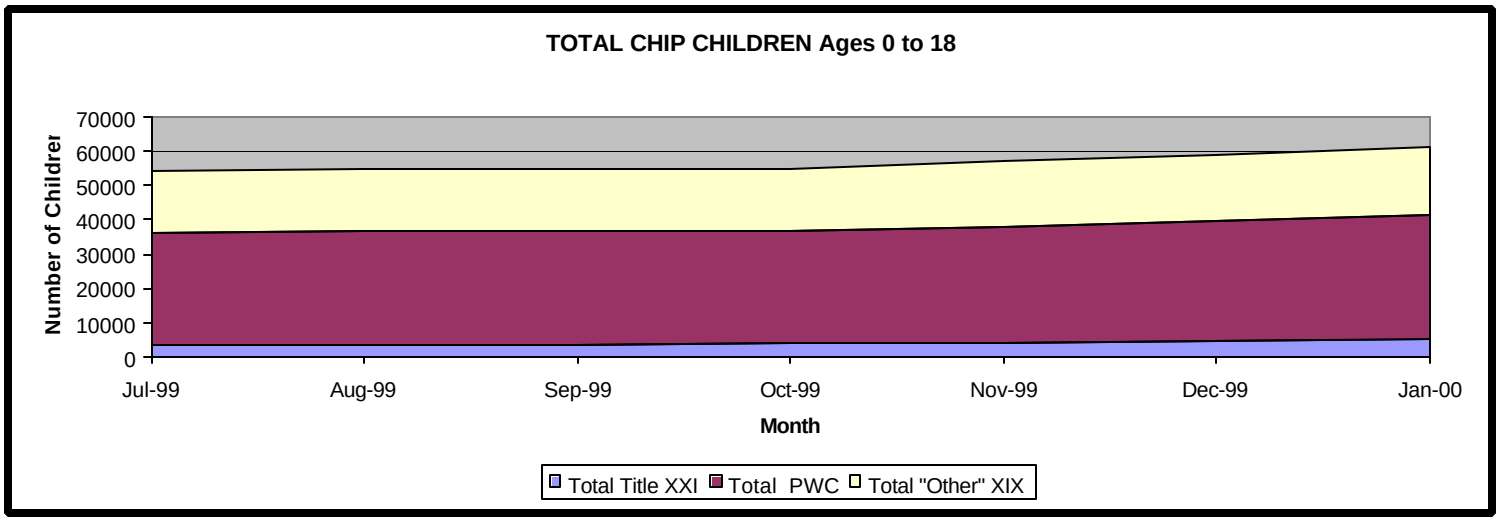
Idaho has chosen to take a broad view when implementing CHIP. For Idaho, the Children's Health Insurance Program encompasses ***all children at or below 150 percent of poverty regardless of funding source through enrollment of children in Medicaid (Title XIX) or CHIP (Title XXI) programs (approximately 35,000 children).***



In the summer of 1999, the Department of Health and Welfare, with the endorsement of Governor Kempthorne, reaffirmed the decision to operate CHIP as a Medicaid expansion and coordinate all enrollment efforts between CHIP and Medicaid. A single message, single streamlined and simplified application, and single outreach and education effort has been developed to target all uninsured children at or below 150 percent of FPL. This approach is designed to make it easy for families to apply for and have their children enrolled in either Title XIX or Title XXI program in a customer friendly, seamless manner. In addition, DHW has eased documentation requirements, eliminated face-to-face interviews and implemented new policies allowing annualization of income, self-

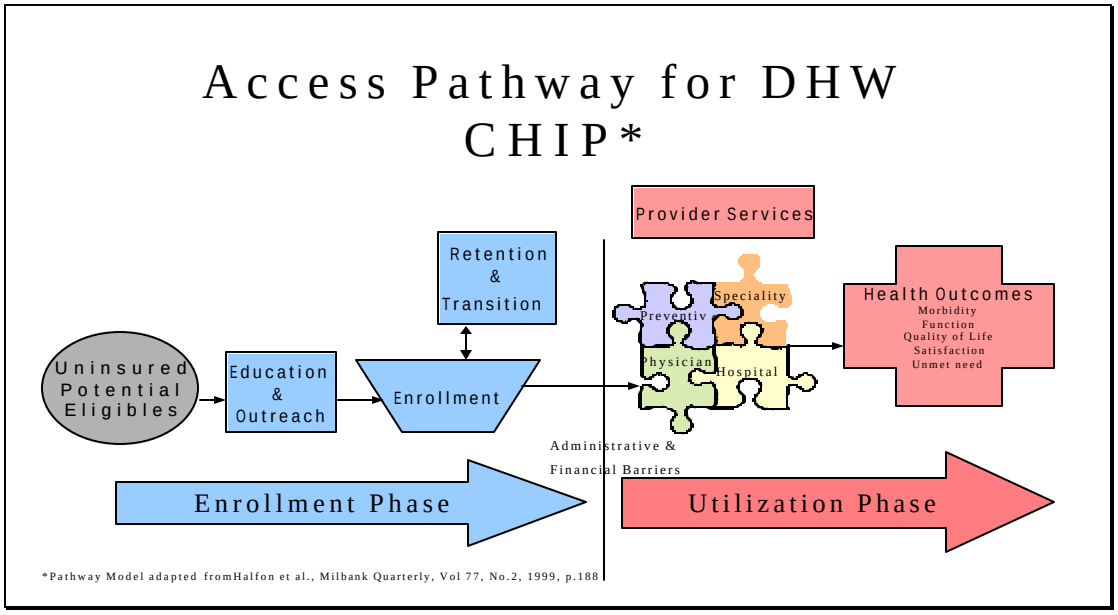
declaration of income and assets, and 12-month continuous eligibility for both programs in order to facilitate enrolling uninsured children. Numerous partnerships have been developed with national and state businesses, health providers, and community agencies to promote CHIP.

Idaho has had significant success in enrolling eligible children. From its inception through September 1999, the Idaho Children's Health Insurance Program has enrolled 17,159 children, of whom 3,735 were enrolled in Title XXI. Since July 1999, with the program design outlined above in place Idaho enrollment has increased to 1,100 children a month in the program.



	Jul-99	Aug-99	Sep-99	Oct-99	Nov-99	Dec-99	Jan-00
Total Title XXI	3,617	3,669	3,735	3,922	4,354	4,728	5,014
Total PWC	32,554	33,027	32,917	32,987	33,803	34,805	36,245
Total "Other" XIX	18,226	18,272	18,172	18,097	18,843	19,513	19,931
Total ALL	54,397	54,968	54,824	55,006	57,000	59,046	61,190

Idaho is now embarking on a new phase of CHIP implementation through a statewide media campaign combined with targeted grassroots outreach activities. These efforts are being implemented in tandem with expanded DHW activities to ensure quality health care access for children. All of these activities are described in greater detail in later portions of this document. The following table provides a framework for the overall design of the Idaho CHIP program.



The Idaho CHIP program is an example of the incremental approach to development of government programs. Idaho was one of the first states to file a state plan with HCFA to begin operation of the CHIP program. The program presented in this document is significantly different than the program initially proposed by Idaho to HCFA in October 1997.

Idaho submitted an amended Title XXI plan in February 2000 to reflect the numerous modifications that this program has undergone since its inception. This amendment is still under review. A copy of the amended plan is provided in Attachment 1. This report builds upon the amended plan in creating a composite picture of the success of the Idaho program.

Changes in the design of the Idaho CHIP program have been a direct outgrowth of Idaho's experience with CHIP implementation and public input. DHW has provided stakeholders with numerous opportunities to assist in design elements. For example, in the Spring of 1998, the Director of DHW appointed a Children's Health Insurance Program Task Force with the charge to obtain public comment and make recommendations on how Idaho should administer CHIP. This task force consisted of 20 individuals representing a variety of interest and backgrounds. They submitted a final report to Former Governor Batt consisting of 60 recommendations on November 16, 1998.

In March of 1999, DHW Director Kurtz formed a CHIP Steering Committee to revisit the Task Force recommendations and make additional recommendations regarding implementation. The steering committee submitted its recommendations to the director on September 28, 1999. Many of the recommendations from these two groups have been incorporated into the Idaho CHIP program design and are presented in this report. In addition, Idaho continues to seek public input in the design through an ongoing quality improvement process and recently implemented customer satisfaction process.

Thus, Idaho brings to this report a significant history in the issues relative to implementing a successful CHIP effort. We are hopeful that the materials presented in this report will help other states and the federal government as we work together to improve the quality of health care available to low-income children in Idaho and in the United States.

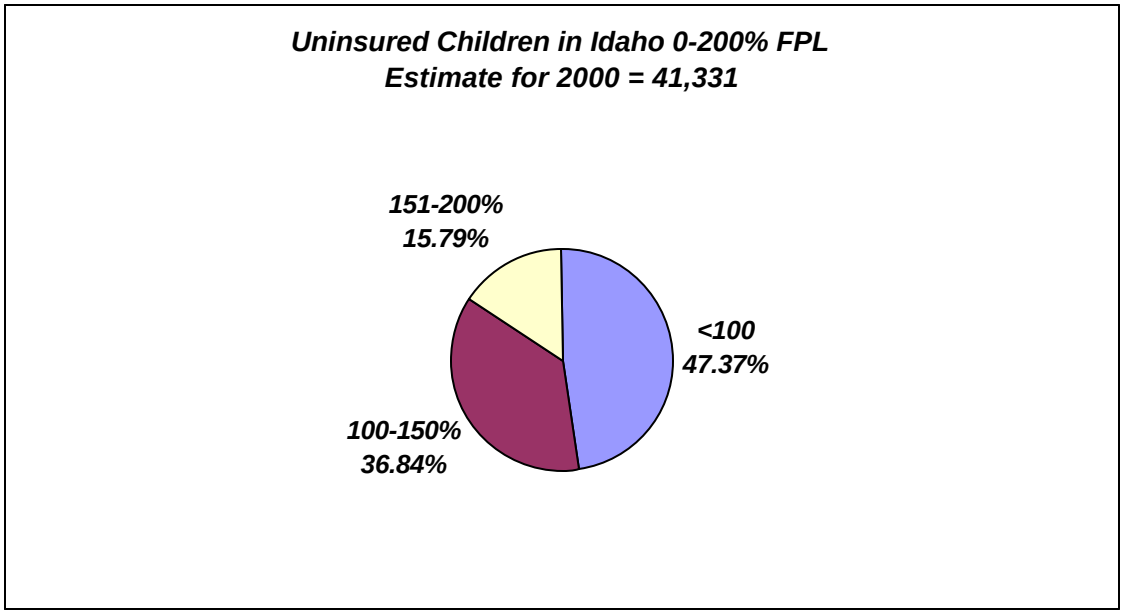
1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

Estimates of the number of children in Idaho and the number of uninsured children have been developed from 1990 Census data, Census Bureau Current Population Survey data, and data developed for the Casey Foundation through the University of Louisville. From these sources, the estimate of the number of children in Idaho in 2000 is 399,167. Of those, 192,515 children live in families with incomes at or below 200 percent of the Federal Poverty Level. Of those children, Idaho estimates that 41,331 are without health insurance. Of all children, there are an estimated 59,821 who are uninsured, or 15 percent of the total.

CHILDREN POPULATION AND INSURANCE DATA: YEAR 2000

FPL	Children	Children w/o Insurance	Percent w/o Insurance	Children w/o insurance cumulative	
<100%	76,135	19,578	26%	19,578	
101-124%	31,542	8,701	28%	28,279	
125-149%	26,104	6,526	25%	34,805	Idaho target
150-174%	29,367	3,263	11%	38,068	
175-199%	29,367	3,363	11%	41,331	Federal target
22-249%	47,857	5,438	11%	46,769	
250+%	158,797	13,052	8%	59,821	
Total	399,167	59,821	15%		

The 1998 Idaho Legislature reviewed the Children's Health Insurance Program and set the upper limit for eligibility at 150 percent of the Federal Poverty Level. **At that level, Idaho estimates that there are 34,805 uninsured children potentially eligible for either Medicaid Title XIX or CHIP Title XXI health insurance.** That number represents 79 percent of the estimated number of uninsured children in Idaho and 84 percent of the uninsured children potentially eligible for CHIP/Medicaid under the federal standard.



To estimate the number of uninsured children who are potentially eligible for the Title XXI Children's Health Insurance Program, the Department started with the 34,805 children at or below 150 percent of FPL. Based upon enrollment experience and the percentages of children who are eligible through the Pregnant Women and Children Program and other Title XIX programs, the Department is estimating that 25 percent of the target population could be enrolled in CHIP. **Idaho estimates that 8,701 uninsured children are eligible to be enrolled in the Title XXI (SCHIP) Program.**

This estimate is different than the data presented in Idaho's 1998 annual report. The Idaho Department of Health and Welfare staff met with representatives of the Idaho Kid Count program and Idaho's Robert Wood Johnson grantee for SCHIP to review the data and develop an agreed-upon figure for the target population of uninsured children. Starting with 1997 data on uninsured children, the group rolled that data forward to arrive at a projection for FY 2000. The numbers are higher than reported in the 1998 report to accommodate for population growth in Idaho.

1.1.1 What are the data source(s) and methodology used to make this estimate?

See 1.1 above.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Section 1.2.2

Idaho's estimate of the potential number of children eligible for enrollment in CHIP is the best available estimate at this time. The estimate was developed in consultation with the Idaho Kids Count data project and thus represents the best thinking of groups working regularly with data on low-income uninsured children in Idaho. The estimate was generated from 1999 Census estimates. These estimates are based on annual random surveys in combination with projections from the 1990 Census.

We believe that these figures may be low. Thus, establishing a confidence interval identifying the range from low to high that this figure might vary is not appropriate. The limitations on this estimate are as follows:

- The Census counts anyone having insurance at any point during the year as being insured. For purposes of Idaho's CHIP, the only criteria is lack of insurance without any waiting period. This lack of comparability in population suggestions the estimate might be low since we would potentially enroll a larger number of eligible children than the census would count.
- Idaho has experienced rapid growth in its general population. Thus, extrapolations may not adequately capture this growth rate. This factor would also suggest that the figure might be low.
- Census figures have traditionally under-counted minority populations. Idaho has experienced a significant increase in its Hispanic population. National census figures indicate that Hispanics make up 35.3 percent of the uninsured (FYI, Idaho Hospital Association, Vol. 15, No. 35, Oct. 15, 1999, pg. 7). Many of the minority uninsured may qualify for this program. This factor would also suggest our estimate may be low.
- The number of uninsured is growing geometrically in this country. In 1995, for example while studying the Clinton Health Plan, the Congressional Budget Office estimated that as many as 100,000 Americans a month may become uninsured (Mann and Ornstein, (Eds.), How Congress Shapes Health Policy, 1995, pg 184). Idaho has moved from the 12th state with highest percentage of uninsured to the 11th highest (FYI, Idaho Hospital Association, Vol. 15, No. 35, Oct. 15, 1999, pg. 6). These figures indicate that all estimates of the uninsured are developed against the backdrop of a rapidly expanding universe. This means that while Idaho is making progress enrolling the children identified in our initial estimates additional children may be entering the uninsured at a more rapid rate than our enrollment activities.

In summary, this document provides the best estimate of uninsured potentially eligible children as of this writing. A more accurate picture will be available after the completion of the 2000 Census. In the interim, we have no basis for establishing a quantitative confidence interval around the qualitative issues outlined above.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

Idaho has made significant progress in increasing the number of children with creditable health coverage. With a ceiling of 150 percent of the federal poverty level on the Idaho CHIP program, most of the children enrolled in the last two years have been enrolled in the Title XIX Program, especially the Pregnant Women and Children Program. The Department of Health and Welfare has data on actual enrollment of children in Title XIX and Title XXI programs from July, 1996 to September,1999. **Enrollment for September 1999 indicates 54,824 children in these programs: 3,735 in Title XXI, 32,917 in the PWC program, and 18,172 in "other" Title XIX programs.** That figure represents 13.6 percent of all children and 40.5 percent of all children at or below 150 percent of the Federal Poverty Level.

Over the last six months, Idaho has enrolled an average of 1,100 children per month in the combined programs. That enrollment rate is 50 percent higher than what has been targeted in the Title XXI Plan Amendment. Also, a combination of actions have been taken beginning October 1, 1999 to spur enrollment. A four-page application, 12-month continuous enrollment, self declaration of income and assets, and income annualization are all projected to increase and to maintain enrollment for Idaho's children.

CHILDREN'S HEALTH INSURANCE ENROLLMENT DATA

CHILD MEDICAID ENROLLEES (7/96)		42,765	
PRE-SCHIP CHILD MEDICAID ENROLLEES (9/97)		37,013	
	TITLE XIX	TITLE XXI	TOTAL
CURRENT MEDICAID/CHIP ENROLLEES (9/99)	51,089	3,735	54,824
ENROLLMENT INCREASE SINCE 9/97	**14,076**	**3,735**	**17,811**

1.2.1 What are the data source(s) and methodology used to make this estimate?

The data for the number of enrolled children comes from the Divisions of Welfare and Medicaid in the Idaho Department of Health and Welfare. It is derived from actual caseload data in the Division of Welfare and actual counts of eligible children in the Division of Medicaid and comes from the automated information systems in those Divisions.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The reliability of the enrollment increase data in Titles XIX and XXI is high. Idaho has a 95 percent confidence level in the data. It has been obtained from actual enrollment data from information systems in the Division of Welfare and Division of Medicaid. The Division of Welfare data is kept at a family case level and extrapolated. The Division of Medicaid tracks each individual with a unique identifier. The two sets of data are reviewed against each other to validate the numbers used to track enrollment increases.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
To enroll 35,000 uninsured children (10/99 estimate) in Title XIX and XXI health programs.	The targeted increase in the enrollment of uninsured children: FY 2000: 8,000 FY 2001: 8,000 FY 2002: 8,000	Data Sources: Enrollment data from the Division of Medicaid AIM system. Methodology: Annual increase in enrollment of uninsured children in both programs compared to the previous federal fiscal year. The total number of new uninsured children enrolled in both programs compared

Table 1.3		
	FY 2003: 8,000	to the base number of enrollees as of 9/30/97 Data Element: Number of enrollees on 9/30 of each FFY Progress Summary: As of 9/30/99, Idaho has seen an increase of 46.4 percent in the number of enrolled children.
To design and implement a sustainable, community-based education and outreach program.	State level and regional outreach and education plans are developed and implemented by 12/31/00. Applications and application assistance are available to target groups in a minimum of 75 percent of Head Start, WIC, and Migrant and Community Health sites and 90 percent of birthing hospitals, with a total of at least 5 sites per region, one of which is a school, by 12/31/00.	Data Sources: Division of Medicaid CHIP Outreach Coordinator Methodology: The Outreach Coordinator will maintain copies of each regional plan and each community outreach grant. Working with field staff, the Coordinator will maintain a database, updated semi-annually, of application assistance locations. Data Element: Number of application assistance locations by type (e.g. Head Start, WIC) Progress Summary: Regional outreach plans are due on 4/14/00. Work has begun on development of application assistance sites, but specific data will not be available until 7/1/00.
OBJECTIVES RELATED TO CHIP ENROLLMENT		
To enroll 8,000 uninsured children (10/99 estimate) in the Title XXI health	The targeted increase in the enrollment of uninsured children: FY 2000: 2,000 FY 2001: 2,000	Data Sources: Enrollment data from the Division of Medicaid AIM system. Methodology: Annual increase in enrollment of uninsured children compared to the previous federal fiscal year.

Table 1.3		
program.	FY 2002: 2,000 FY 2003: 2,000	The total number of new uninsured children enrolled each year. Numerator: Number of enrollees on 9/30 of each FFY Progress Summary: As of 9/30/99, Idaho has a current enrollment of 3,735 children in the Title XXI program.
To simplify and streamline the application and enrollment process.	The application will be customer friendly, 4 pages long, & only request minimum required information by 12/31/99. Applications can be mailed and children enrolled without a required interview by 12/31/99. Results of the customer surveys will be used to make adjustments as indicated by 12/31/00.	Data Sources: Division of Welfare Methodology: Customer satisfaction surveys distributed at time of application and with notices. Numerator: Number of satisfied customers Denominator: Total number of customers Progress Summary: As implementation has just begun, information will not be available until August, 2000. Data Sources: Division of Welfare Methodology: Tracking application activity volume with and without an interview. Numerator: Number of applications processed without an interview. Denominator: Total number of applications processed. Progress Summary: This process has just been started and data is not now available.
To retain enrolled children in Title XXI and XIX programs.	Increase in mean and mode length of enrollment of at least 1	Data Sources: Division of Medicaid information system Methodology: Track length of enrollment periods for children, trend the data

Table 1.3		
	month in each of the next three fiscal years for Title XXI participants.	each quarter. Data Element: New mean and mode each quarter. Compared to the baseline mean of six months and mode of two months established in September 1999. Progress Summary: No data yet available. The most recent HCFA CHIP quarterly report indicates a decrease in disenrollment, most likely due to implementation of 12-month continuous enrollment in Titles XIX and XXI.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
To enroll 27,000 uninsured children (10/99 estimate) in Title XIX health programs.	The targeted increase in the enrollment of uninsured children: FY 2000: 6,000 FY 2001: 6,000 FY 2002: 6,000 FY 2003: 6,000	Data Sources: Enrollment data from the Division of Medicaid AIM system. Methodology: Annual increase in enrollment of uninsured children in Title XIX programs compared to the previous federal fiscal year. The total number of new uninsured children enrolled in Title XIX programs compared to the base number of enrollees as of 9/30/97 Data Element: Number of enrollees on 9/30 of each FFY compared to the number of enrollees on 9/30/97 Progress Summary: As of 9/30/99, Idaho has seen an increase of 36.3 percent in the number of enrolled children.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
To ensure that enrolled children have a medical home.	There will be a 10 percent annual increase in the number of children participating in Healthy Connections and having a primary care provider as a	Data Sources: Division of Medicaid, Healthy Connections (PCCM) Program Methodology: Baseline data on the number of children in the Healthy Connections is known. The data system will track new enrollees in the program Data Element: Number of children enrolled in HC at reporting period compared to the number of children enrolled in Titles XIX and XXI.

Table 1.3		
	"medical home".	Progress Summary: No data available at this time. Data Sources: Division of Medicaid, Healthy Connections and Idaho Board of Medicine. Methodology: The total number of primary care physicians and physician extenders will be tracked along with those that choose to participate in the Healthy Connections PCCM Program. Numerator: Number of participating physicians and extenders. Denominator: Total number of primary care physicians and extenders. Progress Summary: No data available at this time.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
To ensure that enrolled children receive appropriate and necessary medical care.	90 percent of enrolled children will have up-to-date, age-appropriate vaccinations. 80 percent of enrolled children age 12 months and younger will have received appropriate preventive care.	Data Sources: Division of Medicaid information system, Division of Health Immunization Registry Methodology: Claims data will be reviewed for preventive care visits. The immunization registry will be used to track immunization levels once it is operational. Numerator: Number of children with up-to-date immunizations and preventive care visits. Denominator: Total number of Title XIX and XXI children. Progress Summary: No data available at this time.
OTHER OBJECTIVES		
To implement a	Preferred health	

Table 1.3		
quality improvement process for children's health.	outcomes and care management strategies for children will be identified by 12/31/00.	

Introduction:
Idaho has created a CHIP Quality Improvement Committee comprised of Departmental and community representatives. This committee meets three times per year to track the progress Idaho is making in achieving these goals and objectives and to provide ideas for program improvement. The goals listed here come from the amended Title XXI plan recently submitted to HCFA. The goals and objectives listed in this report are new changes and have not yet been approved by HCFA. Data on these new goals and objectives will be included in the 2001 annual report to HCFA. To date, much of the focus of effort in Idaho has been on outreach and enrollment increases. The next steps for Idaho are to ensure access to care and the quality of care provided to CHIP children.

Goal 1: To increase the enrollment of uninsured children
In the two years included in this report, Idaho has increased enrollment by 17,159 children in Title XIX and XXI programs. While this is making a significant impact on the number of uninsured children in Idaho, it is not valid to subtract the increased enrollment number from the estimate of uninsured children. Idaho believes that the estimate is low to start with and with changing demographics, children being enrolled in Title XXI and XIX programs are being offset by new uninsured children. To date, Idaho has not seen a change in the percentage of our population who are uninsured. Idaho is hopeful that new census data will give us a better estimate of the current number of uninsured children. At this point, there has been a steady growth of children being enrolled. This indicates that significant work still needs to be done.

Goal 2: To develop and implement state and regional outreach plans As described in Section 3.4, Idaho has engaged in a variety of outreach activities since the inception of CHIP. Formal outreach plans are just now in development and will be completed by April 15, 2000. More comprehensive data on outreach activities will be available by December 31, 2000.

Goal 3: To make applications and application assistance available to target groups
Applications and application assistance are being provided in a variety of locations such as hospitals, provider offices, and migrant and community health clinics. However, Idaho has not tracked specifically the numbers as indicated in the goal as of now. Specific data on this goal should be available by July 1, 2000.

Goal 4: To increase CHIP enrollment by 2,000 children per year
During the past two years, Idaho has enrolled 3,735 children in Title XXI. This amounts to slightly over 1,850 children per year. While this is close to the target, it is still below. Idaho believes that the more aggressive media campaign and outreach efforts initiated in January 2000 should result in achievement of this goal.

Goal 5: To develop a shortened application form
While not accomplished during this reporting period, Idaho has implemented a new 4-page application effective November 1, 1999. Idaho is currently reviewing the effectiveness of the application and surrounding processes to refine and improve its effectiveness. Data on this should be available by September 2000. *See Attachment 2a & 2b*

Goal 6: To increase the number of mail-in applications
Applicants have always been able to mail in an application; however, the previous reporting requirements almost always required an interview. The new process is designed to expedite handling of the mail-in application by limiting supporting documentation to only materials required for Medicaid. At this time, Idaho does not have data on the actual numbers of mail-in applications and the number processed without an interview.

Goal 7: To use the results of customer surveys to improve the application process
Idaho has just implemented a customer satisfaction survey on March 15, 2000. Information from those surveys will be analyzed and used for process improvements. It is projected that by December 31, 2000 sufficient data will be obtained from the surveys to implement process changes.

Goal 8: To increase the mean and mode length of enrollment
Data from August 1999 indicated a mean enrollment period of six months and a mode enrollment of two months. Data from quarterly reporting through the end of FFY 99 indicate a mean of 5.7 months. Idaho will continue to track both mean and mode lengths of enrollment quarterly. It is believed that the shift on November 1, 1999 to a 12-month continuous enrollment will have a significant positive impact on both of these measures.

Goal 9: To increase the number of children enrolled in Title XIX programs
During the two years of this report, Idaho enrolled 13,424 children in Title XIX programs, or 6,712 per year. This is above the target of 6,000 per year. At this point in FFY 00, Idaho is again on target to enroll more than the 6,000 projected. As of February 29, 2000, Idaho has enrolled 7,289 children in these programs, only five months into the fiscal year.

Goal 10: To increase the number of children participating in the Healthy Connections (PCCM) Program
The Idaho goal is to increase participation by 10 percent per year. Idaho does not have data on this goal at this time. It is expected that preliminary data will be available by September 2000.

Goal 11: To achieve a 90% immunization rate for enrolled children
Current immunization rates in Idaho are reported at 75 percent. Currently, a new statewide immunization registry is being implemented which should aid in more accurate reporting of immunization information for both Title XIX and Title XXI children.

Goal 12: To achieve an 80% rate of preventive care for enrolled children.
Claims data will be reviewed for achievement of this goal. Idaho does not currently have data available on this goal.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

_X_ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: _CHIP, the Idaho Children's Health Insurance Program

Date enrollment began (i.e., when children first became eligible to receive services): ___October 1, 1997

___ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

Introduction

Idaho is one of the fastest growing states in the United States. Over the past 10 years, Idaho's population has grown 24.3 percent. There are an estimated 88,284 Hispanics and migrants living in the state. There are five Indian nations with reservation land in Idaho. While Idaho is experiencing rapid population growth, it remains a largely rural state. Twenty-one (48 percent) Idaho counties are designated as rural ($\geq$ 6 persons/square mile and no population center $\geq$ 20,000 persons) and 16 (36 percent) are frontier (<6 persons/square mile and no population center > 20,000 persons). The lay of the land and density of the population raise challenges to the delivery of health care to many of Idaho's children and families.

Idaho has experienced rapid economic growth over the past 10 years but because of the rural nature of the state, there remain large pockets of poverty. The unemployment rate in Idaho's mostly rural counties dependent upon forestry and mining industries hovers at 10 percent. In addition, many children live in poverty. Idaho Kids Count found that the number of children in poverty had declined in the latter 1980s, but "the percentage of Idaho children in poverty has not shown any further improvement through 1996 despite a healthy economy and low unemployment rate" (Idaho KIDS COUNT 1999/2000: *Profiles of Child Well-Being*, pg. 5). The KIDS COUNT data presents other indicators suggesting a mixed picture of Idaho children's health including:

- "After a steady decline from 1989 to 1995, the percentage of babies born to mothers without adequate prenatal care increased in 1996 and remains at an elevated level in 1998 at 30 percent
- Among babies born to teen mothers, 40 percent were without the benefit of adequate prenatal care in 1998.
- Idaho's low birth weight rate has been inching upward, from 5.4 percent in 1992-94 to 6.0 percent in 1996-98" (Idaho KIDS COUNT 1999/2000: *Profiles of Child Well-Being*, pg.5).

In November1998, Idahoans elected Republican Dirk Kempthorne as their Governor. In February 1999, Governor Kempthorne appointed Karl Kurtz as director of the Department of Health and Welfare (as noted in other parts of this report DHW is the umbrella agency responsible for implementation of CHIP). Governor Kempthorne successfully ran on a platform of improving services to Idaho children. The Governor's theme has been that this is the "Generation of the Child." Given the Governor's priority on children, CHIP has been a high priority subsequently Mr. Kurtz has spent considerable time with the Idaho Legislature developing a strong base of support for the many innovations which Idaho has implemented to improve the CHIP program and which are described throughout this report.

The status of health care for low-income children in Idaho can only be understood within the context of the broader Medicaid program. The dramatically escalating costs of the Idaho Medicaid program particularly in long-term care and prescription drugs have caused Idaho policy leaders great consternation (Idaho Statesman, February 28, 2000, IA). A spokesman for the National Conference of State Legislatures indicated that Idaho's proposed increase in Medicaid of 10.4 percent from 1999 to 2000 was the "ninth-highest

increase in the nation…It does show that Idaho is in the top 10 in needing to appropriate additional funds" (Idaho Statesman, February 28, 2000, 9A).

The costs of the overall Medicaid program have grown from $110 million in 1996 to a projected $168 million in 2001. Governor Kempthorne has recommended Medicaid funding at $570 million, which includes $160 million in state funds (Idaho Statesman, February 28, 2000,1A). Given these figures, there was general consensus around the need to reduce $8 million in state funds and the corresponding reduction of $19 million in federal funds from the Medicaid budget. Legislative discussions have also focused on the administrative costs of the Idaho Medicaid program. Idaho pays 8.1 percent of Medicaid benefits as administrative costs, among the highest fourth of the states (Idaho Statesman, February 28, 2000, 1-A).

Recommended legislative modifications to the overall Medicaid program as of this writing include:

1. Make State Veterans homes Medicaid eligible. (Adopted)

It is the intent of the Idaho Legislature that the Division of Veterans Services and the Department of Health and Welfare take the steps necessary to make state veteran's homes providers of services under the state's Medicaid program on or before October 1, 2000. It is further the intent of the Idaho Legislature that for the period July 1, 2000, through June 30, 2001, the cost limits described in Section 56-102(7) and Section 56-102(11) shall not apply to state homes for veterans.

2. Hold medical transportation spending at FY 2000 level. (Adopted)

It is the intent of the Idaho Legislature that the total expenditure for transportation services provided to clients of the state's Medicaid program for the period July 1, 2000, through June 30, 2001, shall not exceed the amount spent in state fiscal year 2000. The department shall consult with providers and advocates of persons receiving transportation services on how to achieve this savings.

3. Place cap on number of ICF/MR beds. (Adopted)

It is the intent of the Idaho Legislature that the number of beds in private intermediate care facilities for the mentally retarded funded by Medicaid, be capped at 486 beds, including any beds planned or under construction. The department shall consult with providers and advocates of persons receiving ICF/MR services on how to implement the cap.

4. Limit reimbursement rates for ICF/MR services at FY 2000 level. (Adopted)

Notwithstanding the provisions of Section 56-113, Idaho Code, it is the intent of the Idaho Legislature that for the period July 1, 2000, through June 30, 2001, rates, including special rates, of private intermediate care facilities for the mentally retarded shall not exceed the rates in effect in state fiscal year 2000.

5. Require the use of generic prescription drugs and research formulary. (Adopted)

It is the intent of the Idaho Legislature that the department of health and welfare require the use of generic drugs to the extent feasible and allowed by law in the state's Medicaid program. The department shall develop a process of prior approval when the physician prescribes drugs other than generic. The department is further directed to research the feasibility of implementing a closed Medicaid drug formulary.

6. Require prior authorization and periodic review of developmental disability agency services. (Adopted)

It is the intent of the Idaho Legislature that a defined process of prior authorization, client assessment, and periodic review be implemented by the department for developmental disability agency services provided to clients of the state's Medicaid program after consultation with providers and advocates of persons with developmental disabilities.

7. Limit reimbursement rates for durable medical equipment at FY 2000 level. (Adopted)

It is the intent of the Idaho Legislature that for the period July 1, 2000, through June 30, 2001, the rates paid for durable medical equipment provided to clients of the state's Medicaid program shall not exceed the rates in effect in state fiscal year 2000.

8. Reduce the total number of physical therapy service visits per year. (Adopted)

It is the intent of the Idaho Legislature that physical therapy services, beyond a specified amount, be prior authorized and that a concurrent review process be established in order to manage utilization and cost.

9. Implement performance requirements for targeted case management and develop a plan to better manage targeted case management. (Adopted)

It is the intent of the Legislature that the Department of Health and Welfare actively oversee targeted case management services received by clients of the state's Medicaid program to ensure that clients are receiving only needed services resulting in desired treatment outcomes. It is further the intent of the Idaho Legislature that private targeted case managers focus more on managing the utilization of services rather than maximizing services provided to clients. The Department of Health and Welfare is authorized to develop and include enforceable prior authorization and performance requirements in provider agreements for targeted case management services to carry out these objectives. The Department shall consult with providers and advocates of clients receiving targeted case management services on how to effect the transition to the prior authorization and performance requirements. It is further the intent of the Idaho Legislature that the Department of Health and Welfare develop a plan to be implemented over a period of time to better manage such services.

10. Require prior authorization and periodic review for mental health services. (Adopted)

It is the intent of the Idaho Legislature that mental health services provided to clients of the state's Medicaid program shall be prior authorized and periodically reviewed through a defined process in order to achieve cost savings. The department shall consult with providers and advocates of clients receiving mental health services on the process for implementing such prior authorization and periodic review.

11. Implement cost sharing for Medicaid services. (Adopted)

It is the intent of the Idaho Legislature that clients participating in the state's Medicaid program share a portion of the cost of providing services to the extent allowed by law. The Idaho Legislature authorizes the department of health and welfare to implement reasonable co-payments and other cost sharing methods as allowed by law. Providers will retain all co-payments collected, and the department of health and welfare will not reduce provider reimbursement rates by the amount of the co-payments**.**

12. Redefine day treatment services for mentally ill. (Adopted)

It is the intent of the Idaho Legislature that day treatment services provided to clients with mental illness through the state's Medicaid program shall be limited to aiding in the transition from acute care to lesser levels of care and to stabilization as a means of preventing hospitalization. Such transition and stabilization services shall include, but not be limited to, a planned

program of three (3) hours per day of group therapy, one (1) hour per day of individual therapy, at least two (2) psychiatric visits every six (6) days, and meaningful group recreational activities. The modification of day treatment services shall be phased in by January 1, 2001. The Department shall consult with providers and advocates of clients receiving day treatment services regarding the means of modifying day treatment services to transitional and stabilization services by the target date.

13. Research for Possible Matches to Private Insurance Coverage. (Adopted)

It is the intent of the Idaho Legislature that the Department of Health and Welfare research the feasibility of reducing Medicaid service coverage to more closely match private insurance coverage when practical.

14. Reduce administrative costs to be more in line with surrounding states. (Adopted)

It is the intent of the Idaho Legislature that the Department review the administrative costs of the Medicaid program to assure cost effectiveness and wherever possible reduce the cost to be more in line with the surrounding states.

15. Promulgate rules and draft legislation. (Adopted)

The Department of Health and Welfare is hereby directed to promulgate the necessary rules in consultation with provider groups and clients in order to fully implement the Medicaid cost control measures upon which this budget is based. The Department shall also draft any required legislation for submittal to the first regular session of the Fifty-sixth Legislature to permanently implement these changes.

16. Department authority and responsibility. (Adopted)

Not withstanding any other provision of law to the contrary, it is the intent of the Idaho Legislature that the Department of Health and Welfare has the authority and responsibility to manage outside organizations and individuals with whom the Department contracts for services. This includes all contracts for any services provided to or on behalf of the Department.

17. Children's Health Insurance Program (CHIP). (Adopted)

It is the intent of the Idaho Legislature that the federal Title XXI Children's Health Insurance Program shall not exceed one hundred fifty percent (150 percent) of the federal poverty level when determining eligibility without prior legislative approval.

18. Children's Health Insurance Program (CHIP) Task Force Recommendation Implementation. (Adopted)

The Idaho Legislature recognizes the work of the Children's Health Insurance Program Task Force appointed by the director of the Department of Health and Welfare. The Department is encouraged to implement the recommendations of the task force to

the extent legally possible and to apply for the necessary federal waivers where required in order to provide basic health care coverage for Idaho's uninsured children.

19. Medically Needy Option. (Failed)

It is legislative intent that the Department of Health and Welfare explore ways of providing Medicaid services consistent with those allowed under the catastrophic health care law, and to report its findings to the first regular session of the Fifty-sixth Legislature.

In summary, Idaho is a fast-growing rural western state experiencing dramatic changes in its economic base. Idahoans are wrestling with the dilemma of a growing split in population between the large population areas where the high tech industry provides competitive incomes and benefits while much of the formerly agricultural/forestry industry is lagging far behind. This split in economic opportunity has resulted in a significant state surplus with a corresponding strong push to return funds to taxpayers. The fiscally conservative nature in Idaho means that state administrators and state programs must be constantly vigilant in ensuring adequate justification as to the need for and quality of state services. Programs for the poor remain under constant pressure to be efficient and implement successful cost control measures without undo hardship on recipients. Although CHIP has received positive marks from both policy makers and advocacy groups, the program is mandated to provide quality services in a cost-effective manner.

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Idaho Children's Health Insurance is a Medicaid expansion. As such, the basic design of the Idaho Medicaid program provided the initial framework for the CHIP implementation. However, as described in other portions of this narrative, Idaho has worked on refining the CHIP program to increase outreach, enrollment and access of low-income children. Innovations in the CHIP program have dramatically affected the structure of the existing Medicaid program. These innovations include but are not limited to provision of 12-month continuous coverage, self-declaration of assets, elimination of face-to-face eligibility interviews and easing of documentation requirements.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

_X_ No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" ? Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

_X_ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
_X_ Provision of continuous coverage (specify number of months 12)
___ Elimination of assets tests
_X_ Elimination of face-to-face eligibility interviews
_X_ Easing of documentation requirements

_X_ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)

After implementation of TANF in July 1997, Idaho's Children's Health Insurance enrollment immediately dropped by 4.5 percent from 25,088 families enrolled in June 1997 to 23,967 families enrolled in July 1997.

The decreased enrollment continued for seven months with an average monthly enrollment of 23,748 families. In the eighth month after TANF implementation, February 1998, enrollment again exceeded the pre-TANF enrollment by reaching 25,300 families.

Each month since February 1998 enrollment has exceeded the June 1997 rate. Between February 1998 and December 1999, Children's Health Insurance enrollment has increased by 15.6 percent to the December enrollment of 29,968 families.
(Source Data – Idaho Department of Health and Welfare Research and Statistics 1/24/200)

_X_ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

_X_ Health insurance premium rate increases

Employers and insurers in Idaho are reporting premium increases. These increases are significant in individual and small group

policies, making them less affordable for low-income persons and families. One major health insurer in Idaho has seen its claims expenses grow from 87 percent of premium dollar in 1994 to 96 percent in 1998 and has suffered underwriting losses in those years.

_X_ Legal or regulatory changes related to insurance

Idaho has a legislative committee exploring the high cost of health insurance premiums with a goal of making health insurance more affordable. In 1994 and 1995, the Idaho Legislature passed the Small Employer and Individual Health Insurance Acts in an effort to impact the number of uninsured Idahoans. The laws require small businesses (2-50 employees) to offer a health benefit plan and insurance companies to accept all small employers applying for coverage regardless of the health condition of their employees. The laws also require insurance companies doing business in Idaho to offer individual health insurance to persons not covered by employment-based plans regardless of the health condition of the individual. While these plans have had an impact on the number of uninsured Idahoans (over 5,000 individual plans), there has been growing pressure on premium increases due to the health conditions of those accessing the plans. The current committee is exploring ways to manage the premium increases so as not to drive out the most medically needy while not costing the insurance companies in medical losses. However, the premiums for these plans are still beyond the reach of many low-income people. For example, a middle-aged couple with a high deductible plan may pay almost $250 per month in premiums.

A recent review of the effect of these new laws is showing that use of health care services has increased dramatically and the additional costs are being absorbed by existing insured people through premium increases. Young overall healthy populations are electing to go without insurance and "non-group" individual plans are increasingly being used for the least healthy individuals. (Blue Cross Report To the Legislative Study Committee on Health Care Coverage).

__X Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)

Idaho is experiencing an increasing consolidation of the health care market in a few insurance providers. (FYI, Idaho Hospital Association, Vol. 15, No. 36, October 22, 1999, pg. 1 & 2).

For example, a major insurance carrier in Northern Idaho, QualMed, notified 5,000 North Idahoans that QualMed would be leaving the Idaho market at the end of 1999. These individuals were transferred to Blue Cross. Thus, they received continuous insurance coverage. However, this change shows a growing consolidation of the health care market (FYI, Idaho Hospital Association, Vol. 15, No. 36, October 22, 1999, pg. 1 & 2).

_X_ Changes in employee cost-sharing for insurance

Two forces have been at work in this area. On the one hand, as premiums increase, some employers have passed that increase on to employees to control costs. On the other hand, employers in highly competitive sectors (technology) have absorbed these costs as a way to retain employees. For most low-income workers, premium and cost-sharing requirements put health insurance beyond their reach.

___ Availability of subsidies for adult coverage
__X Other (specify)

The existing insurers in Idaho have experienced some conflict between themselves and provider groups. For example, a number of physicians have filed a lawsuit against Regence Blue Shield for changes in contracted reimbursement rates. Regence Blue Shield's changes are a move towards the Medicare market index. The Regence Blue Shield fee changes increase fees to primary care providers while reducing rates to specialists. One hundred of the 2,600 physicians participating in the Regence Blue Shield program are involved in the suit and have dropped out of the Regence Blue Shield program (FYI, Idaho Hospital Association, Vol. 15, No. 37, Oct. 29, 1999, pg. 1).

Blue Cross of Idaho is currently in conflict with Eastern Idaho Regional Medical Center in Idaho Falls over payment rates. Blue Cross says that EIRMC's "prices are out of control" (FYI, Idaho Hospital Association, Vol. 16, No. 4, Jan. 28, 2000, pg. 4-5). Blue Cross has offered its policyholders financial incentives to go to other medical centers. Negotiations between Blue Cross and Bannock Memorial Hospital had broken off as of this writing. These contract negotiations affect 8,300 eastern Idaho customers. EIRMC was openly requesting Blue Cross to return to the negotiating table.

_X_ Changes in the delivery system
_X_ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)

Idaho has not seen a great increase in managed care penetration over the past two years. Group Health Northwest in north Idaho and QualMed have pulled out of the Idaho market. Blue Cross and Intermountain Hospital have both developed and marketed managed care products in southern Idaho with limited success. Primary Health and Saint Alphonsus Regional Medical Center are both offering managed care products in southwest Idaho, but the impact to date has not been significant.

Idaho has a low penetration of managed care. There are a low number of physicians per 100 population and low hospitalization rates making managed care approaches less cost effective than in some other locations. In FY 1999, 11.5 percent of the commercially insured market was covered by managed care. This was up eight percent from two years ago. However, by the end of the second fiscal quarter all the managed care programs operating in Idaho were experiencing losses (FYI, Idaho Hospital Association, Vol. 15, No. 37, Oct. 29, 1999, pg. 2)

___ Changes in hospital marketplace (e.g., closure, conversion, merger)
_X_ Other (specify)

Idaho's health care delivery system is being impacted by increased competition among providers.

As Idaho's population and economy grows, the nature of Idaho's health care community is changing. Consistent with changes experienced in other parts of the country, provision of health care in Idaho is becoming more competitive. Several examples are presented here to demonstrate strategic changes in health delivery that capture the nature of the changing health care base.

For example, the number of investor-owned health care facilities is growing. The attitudes of the owners of these facilities towards Medicaid payments in general and services to low-income children are not known. However, if these providers choose not to take Medicaid, it may significantly impact the business of existing providers particularly nonprofit hospitals and services to the low income may be cut as hospitals trim back services in general (Discussions with IHA staff, February 28, 2000).

Other examples of Idaho's increasingly competitive market place include the arrival of privately owned medical imaging company from Orange California, which relocated to Pocatello. An administrator from one of the Pocatello hospitals was quoted as saying, "There is absolutely no need for another medical imager in town" (FYI, Idaho Hospital Association, Vol. 16, No. 8, Feb. 25, 2000, pg. 2).

During this legislative session, a bill was offered to give DHW's State Emergency Medical Communications Center the authority to dispatch air ambulances to emergencies across Idaho. This bill emanated from the opening of a new Access Air Ambulance in Boise which operates in direct competition with the long-standing well-recognized Life Flight provided by Saint Alphonsus Regional Medical Center, also out of Boise (Idaho Statesman, February 28, 2000, B1). The bill was intended to eliminate local response for air ambulances based on reputation and personal knowledge and assigning air ambulance services based on a centralized authority. The bill died in committee but its existence demonstrates the growing competitiveness of the health care market.

Another bill before the Idaho Legislature would require that Idaho hospitals provide further documentation of charity care. During 1999, the Idaho Legislature sided with the Idaho Hospital Association in opposition to county governments in determining that nonprofit hospitals did not have to pay county property taxes. This latest piece of legislation is designed to make hospitals more accountable for providing levels of charity care which meet or exceeds the their potential "property tax liability" (Idaho Statesman, February 27, 2000, 2B).

There have been a number of closures of services or consolidations of services in rural areas because of cost considerations. Several examples of these changes are:

- East and West Shoshone Hospital Districts have merged after a bankruptcy in order to develop a financial base to continue medical services in the area (FYI, Idaho Hospital Association, Vol. 15, No. 44, Dec. 23, 1999, pg. 2)
- Home health services at the Council Hospital were closed because they were not cost effective (FYI, Idaho Hospital Association, Vol. 16, No. 1, Jan. 7, 2000, pg. 3)
- There was also an unpleasant dissolution of former agreements with Western Montana Clinic, Lemhi Medical Center, St. Patrick Hospital, Tamack Corporation affecting health care services in northwestern Idaho (FYI, Idaho Hospital Association, Vol. 15, No. 44, Dec. 23, 1999, pg. 2)

_X_ Development of new health care programs or services for targeted low-income children (specify)

There have been no new programs developed that specifically target low-income children. However, there have been a number of new programs developed or in the process of development that will improve health care services to low-income children. Several of these programs are as follows:

Governor Kempthorne has made immunization of Idaho children the number one priority of his administration. His has set a 90 percent immunization rate for all Idaho children as his target. To achieve this goal, he has been successful in encouraging the Idaho Legislature to approve the development of a centralized state registry in DHW to track immunizations of children. The Idaho KIDS Count 1999/2000 data found that "among Idaho two-year-olds, 76 percent were fully immunized in 1998, still lower than the U.S. rate of 81 percent, but an increase from 64 percent in 1994 (Idaho KIDS COUNT 1999/2000: *Profiles of Child Well-Being*, pg. 136). Governor Kempthorne has appointed a special coordinator to work on improving Idaho's immunization rate. The Immunization program has collected considerable funding from the private sector to finance public relations activities and outreach specifically targeted to improving Idaho's immunization rate.

Saint Alphonsus Regional Medical Center opened a maternity wing in 1998. Last year Saint Alphonsus had over 500 babies born in their new facility. This service is small compared to its neighbor St. Lukes Regional Medical Facility that provided services for over 5,000 births last year. The opening of this facility is notable for a number of reasons. It provides low-income mothers with a choice of hospital services in Ada County. St. Lukes at the present time has been overcrowded on several occasions and has sent mothers to Saint Alphonsus. Also the Saint Alphonsus program was opened in response to requests from insurers for a comprehensive array of services to offer employers when selling insurance. This request demonstrates the growing competitiveness of Idaho's health care community as discussed in the insurance section.

St. Lukes Regional Medical Center has opened a children's hospital that will serve the entire Northwest region. The development of this hospital has significantly enhanced the availability of children's medical specialists in Idaho.

X_ Changes in the demographic or socioeconomic context

_X_ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)

Idaho continues to be one of the nation's fastest growing states. From 1990 to 1999, Idaho's growth rate was 24.3 percent, the third fastest growth rate in the country. From 1990 to 1998, the Hispanic growth rate was 66.8 percent, the ninth fastest in the country. In the past two years, the Idaho population has grown from 1,228,684 to 1,251,700, an increase of 23,016 persons and 1.9 percent. (US Census Bureau Data). Also, the most recent Census Bureau data indicate 12.5 percent of the Idaho population has an income level at or below the Federal Poverty Level (FPL). Thus this increase adds 2,877 people to the population living in poverty. These increases add to the number of uninsured Idahoans at the same time that CHIP is decreasing the number of uninsured children. Idaho does not have accurate data at this time to evaluate the offsets of these two phenomena.

_X_ Changes in economic circumstances, such as unemployment rate (specify)

Over the last two years, the Idaho unemployment rate has dropped, much like the national rate. In 1997, the Idaho unemployment rate was 5.3 percent, in 1999 the rate was 4.4 percent. However, it is not possible to make any significant correlation between the drop in unemployment rate and its impact on the number of uninsured persons in Idaho. The most recent estimates of the uninsured indicate that the percentage of the population without insurance is the same (17.7 percent, US Census Bureau) in 1999 as it was in 1997.

The state unemployment rate is also somewhat deceptive. The unemployment rate is lowest in urban areas such as Boise (3.2 percent) and highest in rural counties largely dependent upon forest and mining industries (10-12 percent). One result of this has been to focus The Robert Wood Johnson Foundation Covering Kids outreach activity in northern Idaho where the regional unemployment is 7.2 percent

___ Other (specify)_____

___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program***
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	The plan serves all geographic areas in the State of Idaho.	N/A	N/A
Age	All children under age 19, some categories of children up to age 21, such as, a teenager who might qualify for the Pregnant Woman and Children Program or a child with special needs.	N/A	N/A
Income (define countable income)	Countable income is the gross earned and unearned income of both the child and child's natural or adoptive parents.	N/A	N/A
Resources (including any standards relating to spend downs and disposition of resources)	The resource standard is $5,000 per family. The equity value of resources is counted. One vehicle per family is excluded entirely. A second vehicle is excluded in a two-parent family if the vehicle is used for work or medical transportation. Conditional eligibility may be granted when non-liquid resources in excess of the resource standard are offered for sale.	N/A	N/A

Residency requirements	Participants must voluntarily live in Idaho and have no immediate intention of leaving.	N/A	N/A
Disability status	Eligibility and enrollment in Medicaid under the Aid to the Aged, Blind, and Disabled program occurs before Title XXI enrollment is considered.	N/A	N/A
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	Potential eligibility and enrollment in Title XIX Medicaid occurs before enrollment in Title XXI is considered. Children who are covered by creditable, private insurance and children who have access to private coverage at no cost are not eligible.	N/A	N/A
Other standards (identify and describe)	Families who drop other coverage with the intent to qualify for Title XXI are not eligible.	N/A	N/A

**Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here ? and indicate who you passed it along to. Name_____, phone/email_____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	__X_Gross	____Net	____Both
Title XXI Medicaid SCHIP Expansion	__X_Gross	____Net	____Both
Title XXI State-Designed SCHIP Program	____Gross	____Net	____Both
Other SCHIP program_____	____Gross	____Net	____Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups	133_% of FPL for children under age _6_____
	100 % of FPL for children aged __6 to 19____
	____% of FPL for children aged _____
Title XXI Medicaid SCHIP Expansion	150% of FPL for children aged ___0 to 19____
	____% of FPL for children aged _____
	____% of FPL for children aged _____
Title XXI State-Designed SCHIP Program	____% of FPL for children aged _____
	____% of FPL for children aged _____
	____% of FPL for children aged _____
Other SCHIP program_____	____% of FPL for children aged _____
	____% of FPL for children aged _____
	____% of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3				
Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Child, siblings, and legally responsible adults living in the household	Y-SSI and AABD recipients not included	Y-SSI and AABD recipients not included		
All relatives living in the household	N	N		
All individuals living in the household	N	N		
Other (specify)				

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.

Enter "C" for counted, "NC" for not counted and "NR" for not recorded.

Table 3.1.1.4				
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings Earnings of dependent children	NC	NC		
Earnings of students	NC	C if between age 18 and 19		
Earnings from job placement programs	C for parents, NC for children	C for parents, NC for children		
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	C	C		
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NC		
Education Related Income Income from college work-study programs	NC if Title IV work study	NC for Title IV work study		
Assistance from programs administered by the Department of Education	NC	NC		
Education loans and awards	Loans-NC Scholarships-C after attendance costs are	Loans-NC Scholarships-C after attendance		

	deducted	costs are deducted		
Other Income Earned income tax credit (EITC)	NC	NC		
Alimony payments received	C	C		
Child support payments received	C-$50 disregard allowed	C		
Roomer/boarder income	C	C		
Income from individual development accounts	C	C		
Gifts	C when amount exceeds $30 per person in calendar quarter	C when amount exceeds $30 per person in calendar quarter		
In-kind income	NC	NC		
Program Benefits Welfare cash benefits (TANF)	C	C		
Supplemental Security Income (SSI) cash benefits	NC	NC		
Social Security cash benefits	C	C		
Housing subsidies	NC	NC		
Foster care cash benefits	NC	NC		
Adoption assistance cash benefits	NC	NC		
Veterans benefits	C	C		
Emergency or disaster relief benefits	NC	NC		
Low income energy assistance payments	NC	NC		
Native American tribal benefits	NC	NC		
Other Types of Income (specify)				

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes _X__ No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	$90 standard-allowed for any individual with earned income $30 and 1/3 disregard with 4 month limit, $30 for 8 additional months. This disregard is only available to recipients. (child's earnings) Not allowable for parents.	NA	$	$

Self-employment expenses	50 percent of gross self-employment OR actual self employment expenses other than depreciation, whichever benefits family	50 percent of gross self-employment OR actual self employment expenses other than depreciation, whichever benefits family	$	$
Alimony payments Received	NA	NA	$	$
Paid	NA	NA	$	$
Child support payments Received	$50	NA	$	$
Paid	NA	NA	$	$
Child care expenses	$175 for dependents age 2 or older when parent works FT. $115 if parent works PT. $200 for dependents under age 2 if parent works FT, $135 if parent works PT	NA	$	$
Medical care expenses	NA	NA	$	$

Gifts	$30 excluded per person per quarter	$	$	$
Other types of disregards/deductions (specify)	$	$	$	$

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups	____No	___X_Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program	____No	__X__Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program	____No	____Yes (complete column C in 3.1.1.7)
Other SCHIP program_____	____No	____Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XXI State-designed SCHIP Program (C)	Other SCHIP Program* (D)
Countable or allowable level of asset/resource test	$5000	$5000	$	$
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*	Yes	Yes		
What is the value of the disregard for vehicles?	Most valuable vehicle is entirely	Most valuable vehicle is entirely	$	$

	excluded. 2nd vehicle in a 2 parent family is also entirely excluded if used for work or medical tranp. All additional vehicle's equity value is counted	excluded. 2nd vehicle in a 2 parent family is also entirely excluded if used for work or medical tranp. All additional vehicle's equity value is counted		
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*	I	I		

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? _X_ Yes ___ No

3.1.2 How often is eligibility redetermined?

Table 3.1.2

Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months			
Every twelve months	**X**		

Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

_X_ Yes ➔ Which program(s)?
Medicaid CHIP expansion

For how long?
12 calendar months

___ No

3.1.4 Does the CHIP program provide retroactive eligibility?

_X_ Yes ➔ Which program(s)?
Medicaid CHIP expansion

How many months look-back?
Three

___ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ➔ Which program(s)?

Which populations?

Who determines?

_X_ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

_X_ Yes ➔ Is the joint application used to determine eligibility for other State programs? If yes, specify.
The joint application is used to apply for Title XXI Children's Health Insurance Program, Title XIX Medicaid, Food Stamps, TANF programs, Child Care Assistance, and Telephone Assistance (See copy of Application for Assistance, Attachment 2, and available on WEB)

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Strengths:

- The 17-page application has been redesigned and is now three pages in length in both English and Spanish.
- Face-to-face interviews are no longer required.
- Self-declaration of income, resources, expenses and most non-financial criteria is permitted.
- Income and resource rules have been liberalized.
- Documentation requirements have been eased.
- Application assistance is available from out-stationed eligibility workers at Federally Qualified Health Centers.
- Access to Spanish speaking interpreters is available in all of our offices and in all the Federally Qualified Health Centers.
- Our broad based advertising and outreach efforts have increased low income Idahoans access to all Department services. These include the Idaho Child Care Program, nutritional services, such as Food Stamps and Women, Infants and Children's Nutrition Program (WIC), and programs for children with special needs.
- The Department partnered with other community leaders and stakeholders in the development and simplification of the CHIP application and policy. Partners include the Idaho Primary Care Association, Idaho Hospital Association, Idaho Citizen's Action Network, and Healthy Outcome for Youth, the RWJ Covering Kids grantee.

Weaknesses:

- Automation updates have not happened as rapidly as policy changes, causing a need for manual eligibility determination in some cases.
- We have discovered through the CHIP enrollment process that we need to simplify access to services for the other programs. We have developed a strategy that we are now implementing to address this issue.
- Rapid changes in the CHIP program continue to impact field operations. The Department is analyzing ways to better help the field adjust to rapid enrollment changes.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Strengths:

- All of the strengths identified in 3.1.7 also apply here. The most important ones for redetermination are:
  - ✓ Annualization of income
  - ✓ Twelve month eligibility

Weaknesses:

- While all the eligibility determination improvements also significantly enhance eligibility redeterminations, we are committed to designing a simplified renewal process. A committee is currently working on this process.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

Table 3.2.1 CHIP Program Type _____

Benefit	Is Service Covered? (✓ = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T		
Emergency hospital services	T		6 per year
Outpatient hospital services	T		
Physician services	T		
Clinic services	T		
Prescription drugs	T		
Over-the-counter medications			
Outpatient laboratory and radiology services	T		
Prenatal care	T		
Family planning services	T		

Inpatient mental health services	T		
Outpatient mental health services	T		Limits by clinic or rehab option and by service category
Inpatient substance abuse treatment services			
Residential substance abuse treatment services			
Outpatient substance abuse treatment services	T		Same as O/P Mental Health benefit
Durable medical equipment	T		Must meet medical necessity standard
Disposable medical supplies	T		
Preventive dental services	T		
Restorative dental services	T		
Hearing screening	T		1 per year
Hearing aids	T		1 per lifetime
Vision screening	T		1 per year or significant change
Corrective lenses (including eyeglasses)	T		Lense with each significant change, frames: every 4 years
Developmental assessment	T		12 hours per year
Immunizations	T		
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T		100 visits per year
Speech therapy	T		250 sessions per calendar year

Occupational therapy	T		30 hours per week combined with developmental therapy
Physical rehabilitation services			
Podiatric services	T		
Chiropractic services	T		2 visits per month
Medical transportation	T		
Home health services	T		100 visits per year
Nursing facility	T		
ICF/MR	T		
Hospice care	T		
Private duty nursing	T		
Personal care services	T		16 hours per week
Habilitative services	T		30 hours per week
Case management/Care coordination	T		PCS: 8 hours per month, MH, DD, ESPDT varies by program
Non-emergency transportation	T		
Interpreter services	T		
Other (Specify)			
Other (Specify)			

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Because Idaho has chosen to make CHIP a Medicaid expansion, the program has the same scope of benefits as the Idaho Medicaid program. There is no cost sharing. The scope and range of the Idaho Medicaid program provides for comprehensive preventive services under the EPSDT program as well as medically necessary specialty care for children with special health care needs. Because they are on the Medicaid program they are eligible for enabling services such as transportation, interpretative services, home health etc. needed to access care.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3

Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Number of MCOs			
B. Primary care case management (PCCM) program	X		
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)			
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	X		
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)

_X_ No, skip to section 3.4

___ Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____ ____
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
___ Family
___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

Introduction

Idaho has begun implementation of its Outreach and education plan as described in the Idaho Title XXI amendment submitted March 2000. *A copy of the conceptual Outreach and Education plan is provided in attachment #3.* Key elements of the plan are excerpted from that plan and presented below:

Idaho has developed a multi-dimensional approach to outreach including but not limited to:

- Building on existing regional successes through emphasis on targeted, grass-roots outreach.
- State level coordination across all DHW Divisions. The state level has an internal project work team with representatives across DHW described in Section 2.2.
- Establishment of a virtual resource network for CHIP. Membership will include all planning partners from throughout Idaho. The network will provide for ongoing dialogue and collaboration about program direction.
- Supporting regional efforts through a statewide public relations effort and professionally designed promotional materials
- Provision of technical assistance to regional efforts through outreach support teams
- Provision of funding to assist in implementing regional plans through community outreach contracts. Community outreach contracts may range from $5,000 to $20,000 for approved activities. These funds are available to regions to help reach targeted groups defined in the regional plans. Regional planning teams will solicit and select applicants using the model RFP designed by the CHIP Performance Improvement Team. Contracts for services will be with the Region and the selected provider.
- Using Vista Volunteers. Regional Directors can request a VISTA Volunteer. Medicaid will provide the necessary funds to provide the match to the Americorps contribution. Vista workers will be used for CHIP community outreach and education efforts. This program would be modeled after the nationally recognized Idaho VISTA immunization project

Regional activities are based on a regional plan. *A sample of the regional planning template is provided in attachment #4*. The plan is developed and implemented under the direction of the Regional Director with the assistance of Healthy Connection Staff. The Healthy Connections staff is part of the Division of Medicaid but located in regional offices. The staff has primary responsibility for Medicaid's Primary Care Case Management Program. The planning process is intended to bring interested stakeholders to the table to share ideas and enhance coordination of outreach/education/enrollment for CHIP throughout the region. The regional plan includes at a minimum:

- Targeted groups for the region
- Message and approach for reaching each group including strategic outreach partners i.e. schools, HeadStart, WIC
- Potential partners to assist enrollees in completing applications i.e. hospitals, primary care clinics
- Priorities for community outreach contracts
- Potential business partners and recruitment strategy to involve these partners
- Potential staff resources

The grassroots/regional activities are being supported by media activities. DHW has established a media contract to provide professional assistance in the design and implementation of the CHIP media campaign. Media activities include but are not limited to:

- A standard logo
- New posters in both Spanish and English
- Business cards in English on one side and Spanish on the other
- Television advertisements. The ads started in February 2000 with a rotating schedule over the next two years
- CHIP phone number will be in all Idaho telephone directories under government, business, & in yellow pages
- A Spanish language outreach component will be developed and will include Novellas on Spanish radio, Spanish print ads, and Spanish radio spots
- Prices of billboards are being investigated
- Underwriting a children's public television show is being considered
- Radio ads targeted to mothers and fathers emphasizing working parents in the 21-34 age bracket will be developed

Table 3.4.1 presents all client education and outreach approaches used in the Idaho CHIP program. The effectiveness rating is a qualitative measure developed in consultant with the project management team responsible for implementation of the CHIP program. The effectiveness scale is based rating of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2 identifies all the settings used by the Idaho CHIP program for client education and outreach. The effectiveness rating is a qualitative measure developed in consultant with the project management team responsible for implementation of the CHIP program. The effectiveness scale is based rating of 1 to 5, where 1=least effective and 5=most effective

Attachment #5 presents the outreach activities undertaken by region. These tables demonstrate the grassroots nature of Idaho's regional outreach approach.

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (✓=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____ ____	
	✓ = Yes	Rating (1-5)	✓ = Yes	Rating (1-5)	✓ = Yes	Rating (1-5)
Billboards						
Brochures/flyers	T	3				
Direct mail by State/enrollment broker/administrative contractor						
Education sessions	T	4				
Home visits by State/enrollment broker/administrative contractor						

Hotline	T	4				
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake	T	4				
Prime-time TV advertisements	T	5				
Public access cable TV						
Public transportation ads						
Radio/newspaper/TV advertisement and PSAs	T	5				
Signs/posters	T	3				
State/broker initiated phone calls						
Other (specify)Community Health Fairs and Professional Conferences and Meeting Displays	T	3				
Other (specify)						

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (✓=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	✓ = Yes	Rating (1-5)	✓ = Yes	Rating (1-5)	✓ = Yes	Rating (1-5)
Battered women shelters	T	3				
Community sponsored events	T	3				
Beneficiary's home						
Day care centers	T	4				
Faith communities	T	3				
Fast food restaurants						
Grocery stores	T	2				
Homeless shelters	T	3				
Job training centers	T	4				
Laundromats	T	2				
Libraries	T	2				
Local/community health centers	T	4				

Point of service/provider locations	T	4				
Public meetings/health fairs	T	3				
Public housing						
Refugee resettlement programs						
Schools/adult education sites	T	4				
Senior centers						
Social service agency	T	4				
Workplace	T	2				
Other (specify)Indian Health Centers and Reservations	T	4				
Other (specify)Public Health & WIC offices	T	4				

Tables indicating activities in each Health and Welfare Regions are included as Attachment # 5.

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Idaho has limited data tools with which to determine the effectiveness of outreach activities. The two best measures are calls to the CareLine related to CHIP and actual enrollment trends. Both of these measures suggest that Idaho's recent efforts to increase enrollment through streamlined processing approaches and increased outreach activities are working. Tables showing the increase in enrollment are contained in the introduction to this document.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

DHW has placed a high priority on reaching minority families living in Idaho through targeted outreach activities. Idaho's predominate minority groups are Native Americans and Hispanics. There are five Tribal Nations in Idaho. Idaho has a large migrant population who work in Idaho's agricultural sector. Activities specifically targeted towards reaching these minority groups include but are not limited to:

- DHW meets quarterly with the Tribal leadership to discuss issues of mutual concern. CHIP is discussed at each of these meetings.
- Tribal and Hispanic representatives were included in the Steering Committee that was responsible for the basic design of the Idaho's outreach activities.
- Tribal and Hispanic representatives were included in the focus groups that reviewed various materials developed as part of the outreach and education efforts.
- Idaho has arranged for VISTA workers to be stationed in each of the DHW regions. At present, plans are in place to recruit a tribal representative into at least one of the VISTA positions in Regions 1, 2 and 6. Tentative plans are in place to recruit a Hispanic to one of the VISTA positions in Region 3.
- The regional planning approach and community outreach contracts are specifically designed to encourage grassroots outreach and education efforts to minority populations. As of this writing, specific proposals are not available from regions. We anticipate that these proposals will reflect innovative approaches to reach minority populations.
- A series of media activities have been developed to reach Idaho's large Hispanic population. These include Spanish speaking posters, flyers, cards radio spots and Novellas.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

Idaho is in process of implementing its comprehensive outreach and education activities as described above. At this juncture, it is premature to assess the effectiveness of any particular innovation.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	Medicaid*	Maternal and child health	Other (specify) Community and Migrant Health Centers	Othe Publ
Administration		T		
Outreach		T	T	T
Eligibility determination			T	
Service delivery			T	T
Procurement				
Contracting			T	
Data collection			T	
Quality assurance				
Other (specify)				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.
DHW Director Karl Kurtz has made integration of health care services to children a major priority of his administration. Service integration is the "systematic effort to solve problems of service fragmentation and of the lack of an exact match between…a family with problems and needs and an intervention program or professional specialty." (Kahn and Kamerman 1992). Integrating services is a strategic way to address service gaps. Through service integration, agencies and programs make the best use of their talents and expertise while reducing duplication of efforts. The benefits of regular communication, information sharing and joint planning result in the assurance that appropriate referrals are made and can eliminate barriers for both clients and staff.

In order to improve service integration and coordination throughout the Department, DHW staff has developed a "Tool Kit" designed to serve as a framework. The entire Tool Kit is available upon request from the Idaho Division of Medicaid, Department of Health and Welfare, Contact: MooreDx@mmis.state.id.us. The Tool Kit describes a generic process for any service integration project with emphasis on managing integration and coordination through multiple levels of authority and review. The focus on the Tool Kit is on service integration and coordination from the perspective of the customer. Samples of possible memorandums of agreements for referrals, a charter for establishing a coordinating council and a description of fundamental techniques in project measurement are included in the Kit.

Other areas where DHW has worked on service coordination include but are not limited to:

Working with the Health Districts
Activities have included:

- Development of Outreach activities to WIC, immunization and family planning populations. Future plans include expanding the service integration project to WIC recipients.
- Establishment of a performance improvement team comprised of representatives from the health districts, and DHW to outline and encourage streamling of various customer service activities.

Working with Migrant Health Centers
Activities have included:

- Development of an out-stationed eligibility workers program.
- Development of center specific CHIP brochures and posters in English and Spanish.
- Development and implementation of presentations to families and community groups about CHIP and offering application assistance.

Working with Schools
Note school outreach efforts are school district focused. The following is an example of efforts of coordination and does not reflect activities that have occurred statewide:

- Distribution of applications
- Dissemination of information about CHIP at enrollment

Statewide activities that are planned include:

- Information dissemination in the Fall of 2000
- Distribution of an endorsement letter for the State Superintendent of Schools scheduled to go out 4/2000 to all District Superintendents.

3.6 How do you avoid crowd-out of private insurance?

The Idaho Legislature and the CHIP Task Force were both very concerned about families dropping their health insurance to enroll their children in CHIP. The Idaho Legislature in 1998 dropped the upper income limit for CHIP from 160 percent to 150 percent of the Federal Poverty Level (FPL). The result of using 150 percent of the FPL as the income limit on the Idaho Children's Health Insurance Program has been to make crowd out an insignificant issue. Also, the CHIP Task Force developed a set of recommendations to minimize crowd out by allowing a graduated voucher system for individuals between 150 percent and 200 percent of the FPL should Idaho choose to extend coverage.

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

_X_ Eligibility determination process:

___ Waiting period without health insurance (specify)
_X_ Information on current or previous health insurance gathered on application (specify)
Information on current health insurance is asked on the application. If insurance exists and if the child qualifies for Title XIX or Title XXI, then those programs are secondary to the primary insurance program.
___ Information verified with employer (specify)
___ Records match (specify)
___ Other (specify)
___ Other (specify)

___ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing (specify)
___ Other (specify)
___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Due to the low income cap on program eligibility, Idaho has not formally monitored crowd out. Medicaid/CHIP administration has not received any substantial anecdotal information that would indicate that crowd out is a problem in Idaho.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

As can be seen in the chart, the majority of children enrolled in the Title XXI program are in the 6-12 and 13-18 age ranges. This is due to two factors: an upper income limit of 150 percent of the federal poverty level and the income limits in Idaho's PWC program. Children 0-6 are eligible for Medicaid through PWC up to 133 percent of the FPL. Children 7-18 are eligible at 100 percent of the FPL. Thus, as discussed earlier, the majority of uninsured children are enrolled in Title XIX programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

Table 4.1.1 CHIP Program Type : Medicaid expansion						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	5331	8482	5.0	5.7	1854	4730
Age						
Under 1	46	78	6.6	9.4	44	40
1-5	494	630	4.6	4.9	284	397
6-12	1591	3099	5.3	5.8	571	1739
13-18	3200	4675	5.0	5.8	955	2554
Countable Income Level*						
At or below 150% FPL	5331	8482	5.0	5.7	1854	4730
Above 150% FPL						
Age and Income						
Under 1						
At or below 150% FPL	46	78	6.6	9.4	44	40
Above 150% FPL						
1-5						
At or below 150% FPL	494	630	4.6	4.9	284	397
Above 150% FPL						
6-12						

At or below 150% FPL	1591	3099	5.3	5.8	571	1739
Above 150% FPL						
13-18						
At or below 150% FPL	3200	4675	5.0	5.8	955	2554
Above 150% FPL						
Type of plan						
Fee-for-service	5331	8482	5.0	5.7	1854	4730
Managed care						
PCCM						

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

This information is not available at this time.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

The combination of the Small Employer Health Insurance Act and Individual Health Insurance Act passed five years ago have had some impact on the number of uninsured Idahoans by enrolling over 5,000 families and individuals in health insurance. However, the percentage of uninsured Idahoans compared to the total population has remained constant. Population growth and increases in the number of uninsured people are offsetting the effects of these laws. The

insurance companies are reporting that the plans provided under these acts are not profitable and that many high-risk people are using them. The result is a significant premium increase which has caused some individuals to disenroll. No other initiatives are underway in Idaho that are having any significant impact on reducing the number of uninsured children.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? **1,854 in FFY 1998 and 4,730 in FFY 1999.**
Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? **Disenrollment was higher than expected and length of enrollment in CHIP was shorter than expected. These results triggered the survey done by the Division of Welfare in late 1999.**

How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates? **This information is not available. The implementation of 12-month continuous eligibility in both programs is expected to stabilize disenrollment rates at similar levels.**

In August 1999, the Division of Medicaid studied the length of enrollment in CHIP. It found that the mean period of enrollment was six months, but the modal length of enrollment was only two months. The vast majority of children were disenrolling before a redetermination would need to be done. Idaho redetermines program eligibility at 12 months unless family circumstances change. Families have been required to report changes in such things as income, resources, and family size. As a result of the initial study, the Division of Welfare initiated a study of a random sample of CHIP enrollees to determine what was happening to them in more detail. A statistically valid sample of 945 children was selected and studied. *The study is attached as Attachment #6.* One significant finding of the study was that there were many children who moved between CHIP and Medicaid because of changes in program eligibility. Some of the significant findings are:

- 54 percent of children had uninterrupted Medicaid months either prior to and/or following CHIP months. This group averaged 5.9 months on CHIP and 27.2 consecutive Medicaid months.
- 46 percent had CHIP only for an average of 8.4 months, of those, 57 percent had Medicaid coverage during some prior period.
- 67 percent of the children closed for not completing a redetermination are ages 15-19.
- In the sample, 55 percent of the children were currently enrolled in either Title XIX or XXI, 45 percent were closed in both programs.
- 25 percent of the sample moved from CHIP enrollment to Medicaid enrollment.
- Income changes were the primary reason for case closure (28.8 percent). Note: this figure is skewed because some in the sample were closed when the Idaho Legislature lowered the eligibility limit from 160 percent of FPL to 150 percent of FPL.
- Lack of verification (14.8 percent), no redetermination (13.7 percent), and aging out (13.1 percent) were the other major reasons for disenrollment.

- Only 8.8 percent of the sample who closed CHIP and were not transferred to Medicaid were closed because of access to private insurance.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

This information is not available at this time. However, data from the Welfare survey indicate that 35 percent of the CHIP children were enrolled in another Medicaid program at the time of their CHIP closure.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Data for this table come from two sources: the HCFA quarterly enrollment report and the Fall, 1999 Division of Welfare study on disenrollment reasons for CHIP enrollees. The percentages attributed to reasons for discontinuation of coverage are the percentages for discontinuation found in the random sample. The actual number comes from using the percentages against the number of disenrollees who were not picked up in other Medicaid programs.

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	FY99 4,730 W/o Medicaid: 3,547	55.76%				
Access to commercial insurance	312	8.8%				
Eligible for Medicaid	1182	25%				

Income too high*	1022	28.8%				
Aged out of program	465	13.1%				
Moved/died	241	6.8%				
Nonpayment of premium		NA				
Incomplete documentation	525	14.8%				
Did not reply/unable to contact		NA				
Other (specify) No redetermination	486	13.7%				
Other (specify) Residency	241	6.8%				
Resources	71	2%				
Requested closure	92	2.6%				
Other/don't know	92	2.6%				

*Income limits were dropped from 160 to 150 percent of the FPL by the Idaho Legislature in 1998. Some of the income closures were due to this action.

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Idaho has implemented a 12-month continuous eligibility standard for Title XIX and XXI. This should stabilize enrollment and stop the shifting of a child between programs. Idaho is also in the process of simplifying our redetermination process to reduce the administrative barriers to re-enrollment. One option under consideration would require reporting only changes in material elements from the original application rather than a full-scale review of all application elements. Finally, the media campaign that is encouraging enrollment also encourages continuous

enrollment.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 _____$1,562,098_____

FFY 1999 ____$4,465,155_____

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services? **100 percent spent on purchasing direct services.**

Table 4.3.1 CHIP Program Type: Medicaid expansion				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	1,562,098	4,465,155	1,229,528	3,522,563
Premiums for private health insurance (net of cost-sharing offsets)*	0	0	0	0
Fee-for-service expenditures (subtotal)	1,562,098	4,465,155	1,229,528	3,522,563
Inpatient hospital services	371,614	927,079	292,497	731,372

Inpatient mental health facility services	0	299,710	0	236,440
Nursing care services	0	0	0	0
Physician and surgical services	303,068	751,353	238,545	592,743
Outpatient hospital services	106,337	372,374	83,698	293,766
Outpatient mental health facility services	0	0	0	0
Prescribed drugs	171,797	446,599	135,222	352,322
Dental services	345,717	693,526	272,114	547,123
Vision services	0	0	0	0
Other practitioners' services	50,596	110,687	39,824	87,322
Clinic services	72,010	425,299	56,679	335,464
Therapy and rehabilitation services	0	1,009	0	796
Laboratory and radiological services	38,201	124,587	30,068	98,286
Durable and disposable medical equipment	0	0	0	0
Family planning	0	0	0	0
Abortions	0	0	0	0
Screening services	17,775	34,127	13,991	26,923
Home health	1,031	5,079	812	4,007
Home and community-based services	6,965	8,308	5,482	6,554
Hospice	0	0	0	0

Medical transportation	13,826	53,799	10,882	42,443
Case management	10,784	36,406	8,488	28,721
Other services	52,377	175,283	41,226	138,281

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap? Administration, outreach and education

What role did the 10 percent cap have in program design? The 10 percent cap played a significant role in program design. While Governor Batt's Task Force recommended a separate program, the State chose to continue the Medicaid expansion option because of the cost of a stand-alone program and the limited administrative resources that would have been available for match under the 10 percent cap. Idaho did not want to spend 100 percent state funds on the administrative costs above the cap. *Attachment #7* shows the cost difference between a Medicaid Expansion and State Only Program.

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share	173,567	496,129	0	0	0	0
Outreach	25,663	86,896	0	0	0	0
Administration	147,904	409,233	0	0	0	0
Other_____	0	0	0	0	0	0
Federal share	136,614	391,396	0	0	0	0
Outreach	20,199	68,552	0	0	0	0
Administration	116,415	322,844	0	0	0	0

Other _____	0	0	0	0	0	0

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

_X_ State appropriations
___ County/local funds
___ Employer contributions
_X_ Foundation grants (The Robert Wood Johnson Foundation Covering Kids grant through the Mountain States Group
___ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

As noted in other sections of this report, Idaho has approached implementation of the CHIP program as an incremental process. Initial efforts focused on improving outreach and education. We are now in the process of designing a comprehensive approach to evaluate and monitor access to care and to design approaches to improve access. This is not to say that we have not undertaken a number of steps to improve access. These steps include but are not limited to:

- Developing and implementing an ongoing quality improvement structure and quality improvement team to review statistics on CHIP program implementation including access.
- Implementing 12-month eligibility, which allows continuous coverage of children without regard to changes in income. Changing eligibility status was a factor sited by providers as reason for not participating in the Medicaid program.
- Increasing fees to dentists. Fees for dentists remain below usual and customary even with this adjustment.
- Developing a letter to send to all new health care providers in Idaho to encourage their participation in the Medicaid program followed by a personal visit from the Medicaid Healthy Connections staff.
- Developing a system to track the ratio of Medicaid providers compared to the total number of health care providers in Idaho.

- Developing a system to routinely compare health care utilization rates between the CHIP enrollees and the Pregnant Women and Children. This is the most comparable population.
- Developing a baseline for a quality improvement project which long term will assess timeliness and access to care as well as more in-depth issues of quality related to the care provided in specific disease areas such as obstetric, prevention, and infectious diseases. The initial step is to access the current information from Medicaid sources and determine what changes are needed to accumulate the necessary data sets.
- Undertaking a missed appointment research study to determine if the Medicaid population has a higher rate of missed or no-show appointments than the general population. Anecdotal information from physicians suggests that no show rate is one reason that physicians limit their participation in the Medicaid program
- Expanding participation in the Healthy Connections program to more participants and more primary care providers.

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other Progra _____
Appointment audits			
PCP/enrollee ratios	PCCM		
Time/distance standards	PCCM		
Urgent/routine care access standards	PCCM		
Network capacity reviews (rural providers, safety net providers, specialty mix)	PCCM		
Complaint/grievance/disenrollment reviews	PCCM		
Case file reviews	PCCM		
Beneficiary surveys	PCCM		
Utilization analysis (emergency room use, preventive care use)	PCCM		
Other (specify) _____			

In Idaho, participation in the Healthy Connections PCCM program is voluntary. At this time, approximately 50 percent of children enrolled in Titles XIX and XXI participate.

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify) _____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

4.4.2 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Information currently available regarding access to care comes primarily from the Healthy Connections PCCM Program. Healthy Connections field staff maintain an updated list of physicians participating in the program and accepting Medicaid clients. At this time, all pediatricians in Idaho are participating. The Idaho CareLine monitors calls related to service access. The major issue for callers is the availability of dentists who will see a child with a medical card. Each year, Healthy Connections does a customer survey and asks a question regarding access. That survey indicates that access has not been an issue for most respondents. *A copy of the survey and findings are attached as Attachment #7.* Anecdotal information indicates that access is a problem in northern Idaho and some areas of southern Idaho. At this time, Idaho can monitor the percentage of CHIP children using services and compare that to PWC children.

4.4.3 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

The CHIP Quality Improvement Committee has identified access to care as a critical issue as the program unfolds. The plan at this time is to identify indicators of access to care and methods to monitor them and to begin to have data on access by December, 2000.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Pro
Focused studies (specify)	PCCM(Asthma, Immunization, ER use)		
Client satisfaction surveys	PCCM		
Complaint/grievance/ disenrollment reviews	PCCM/FFS		
Sentinel event reviews			
Plan site visits			
Case file reviews	PCCM		
Independent peer review	PCCM/FFS		
HEDIS performance measurement			
Other performance measurement (specify)			
Other (specify) _____			

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Idaho does not now have definitive data on the quality of services provided. The Medicaid/CHIP program has not received grievances related to quality of care issues.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

The CHIP Quality Improvement Committee has identified quality of care as a critical issue as the program unfolds. The plan at this time is to identify indicators of quality of care and methods to monitor them and to begin to have data on access by December, 2000.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

- QI Committee Community members *(Attachment #9)*
- Division of Welfare Customer Satisfaction Survey *(Attachment #10)*
- Comparison of Enrollees to Users: Both PWC and CHIP (*Attachment #11)*
- New application focus group results *(Attachment #12)*

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

Introduction

Implementation of the Idaho CHIP program has been an incremental process. By utilizing evaluation, we feel that our efforts have substantially improved based on our past experiences. Key lessons that we have learned as we have progressed are as follows:

- Committed leadership from the top of the administrative structure is essential. DHW Director Karl Kurtz has successfully supported innovations in this program to the Governor and key legislators. Innovative changes can be difficult and controversial. Top administration must be committed to providing ongoing support in terms of personnel resources, finances, and political capital in order for CHIP implementation to be successful.
- CHIP Program design must be viewed as comprehensive whole. Efforts at innovations in eligibility determination/redetermination and enrollment must be coordinated with outreach and public education. All these efforts must be coordinated with work with both internal and external stakeholders.
- Creative administrators can use CHIP as an opportunity to improve services to children and families throughout an umbrella agency. Efforts at simplification, improved outreach, customer service, and programmatic coordination are important concepts in all the human service programs related to CHIP implementation. Based on the broad internal and external support that CHIP has it can be used as the pilot for attempting innovative design efforts which can be transferred to other programs.
- An outreach approach that emphasizes targeting of high-risk groups and local grass roots planning and implementation of activities enhances enrollment.
- Idaho has established a contract for technical assistance and monitoring of the CHIP program. The independent monitor has provided review of deadlines for implementation across divisions

5.1.1 Eligibility Determination/Redetermination and Enrollment

Idaho has implemented a shortened eligibility application *(Attachment #2)*, which includes mail in applications and elimination of the need for face-to-face interviews for health coverage. We have found that these efforts have facilitated enrollment. Since implementation of the shortened application began, enrollment has steadily grown as indicated in the chart in the Introduction to Section 1. Much of the success of these efforts lies in changing the eligibility process. Also, Idaho spent considerable time and personnel resources in improving our customer service responsiveness in field offices. These efforts included designing and implementing a customer service questionnaire *(Attachment #1)*.

5.1.2 Outreach

Idaho spent considerable time designing a conceptual plan for outreach *(Attachment #3)* which encourages coordination of outreach across departmental divisions and establishes a two level process of state level outreach and media activities and regional level planning and implementation of outreach. Regions have been provided incentives to participate in planning by providing staff to help facilitate the planning process and assist with implementation including state-funded staff through the Healthy Connections program, community outreach contracts funded with TANF funds, and VISTA workers whose salaries are paid through the Medicaid program. These activities are outlined in Region Outreach Plan Template (*Attachment #4*)

5.1.3 Benefit Structure-No significant change

5.1.4 Cost-Sharing (such as premiums, co-payments, compliance with 5 percent cap)-Not applicable

5.1.5 Delivery System-Idaho will be emphasizing access and delivery system issues in the next phase of its CHIP implementation process.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

Idaho has included representatives of the insurance industry on all of its various planning bodies. In addition, Idaho has a Robert Wood Johnson grant to work on piloting successful outreach approaches. A nonprofit group, Mountain States, administers this grant. Writing and submitting of the grant was a cooperative venture between the Idaho Medicaid Division and Mountain States personnel. DHW outreach activities are consistently coordinated with the Robert Wood Johnson Healthy Outcomes for Youth Initiative.

5.1.7 Evaluation and Monitoring (including data reporting)

Idaho has contracted for project monitoring and technical assistance of the Children's Health Insurance Program. This contract has enabled the Department of Health and Welfare to focus its efforts on clear goals with identified timeframes. The Department has also established a CHIP Quality Improvement Committee comprised of both Departmental and community representatives to guide and review the progress of the program, basing the decisions on sound data. Use of the external project monitor has assisted the Department in achieving its goals amid the competing demands of an umbrella human service organization.

5.1.8 Other (specify)

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

Our plan is to find and enroll the approximately 35,000 children without health insurance meeting Idaho's Medicaid (Title XIX) and CHIP (Title XXI) eligibility requirements within the next five years. Idaho is also one of the states that choose to continue HIP when the program became optional. We are committed to enrolling children in CHIP who have other insurance when they meet eligibility requirements.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

First, we hope by the time you the reader have completed a thorough review of this document that you will be convinced that Idaho has committed substantial personnel and financial resources to the successful implementation of CHIP. While Idaho is a conservative state, we have found through objective indicators such as Gubernatorial leadership, legislative action, public meetings, task force and steering committee discussions, and focus group findings that there is wide-spread support of the concept of a publicly funded health insurance program for low income children. We have established a shared vision that:

- Children in Idaho should have access to quality healthcare
- Investing in the health needs of Idaho's children is in the best interest of Idaho
- Emphasis should be placed on utilizing existing resources to maximize meeting these health needs
- Preventive healthcare should be emphasized
- Health care coverage must be administered and delivered in a fiscally responsible manner
- The CHIP program must be designed to encourage personal responsibility, dignity and self-reliance
- Employer sponsored health plans are an important key to healthcare and the CHIP design should encourage the continuation of these plans (Summarized from "Report to the Director, Idaho Department of health and Welfare from: The Children's Health Insurance Program Task Force, November 16, 1998, pg. Opening unnumbered and page 4).

We believe these values are consistent with the general public's beliefs across this country. Thus, we want to be on record emphasizing that we believe there is a need for federally/state funded health insurance program for low-income children. We want to strongly encourage the continuation of this program. We know that the Congressional allocations for this program have not been expended and that national discussions have been underway on how to reallocate these funds. But we believe the Idaho experience provides a barometer for the nation. We have learned from our initial outreach and implementation efforts. The number of enrollees is growing weekly. We would anticipate that throughout the country the numbers of low-income children enrolling in CHIP is increasing. We believe this is a good thing for our children and ultimately our country.

As noted throughout this report, Idaho has undertaken a number of activities specifically structured to include stakeholders in the design of the Idaho CHIP program. In addition, both the Idaho CHIP program and Medicaid program receive ongoing critical scrutiny by the Idaho

Legislature. All of these endeavors have resulted in a series of recommendations to the Federal government to improve the CHIP program. These recommendations include:

- **Develop a national media campaign for CHIP**.

Idaho has recently developed a statewide media campaign around CHIP. We have found a dramatic increase in the numbers of phone calls to our 800 number as soon as the TV advertisement began. We have also found that we have pockets where Idaho television advertising does not reach. These pockets are reached by television in the surrounding states. We are not comfortable buying advertising with state dollars in out-of-state markets. We would greatly appreciate a broadly based national media campaign. If coordinated appropriately, we believe such a campaign would result in an immediate substantial increase in CHIP enrollment.

- **Make the CHIP program more flexible and work on the general image and bureaucratic requirements of the federal Medicaid program.**

As noted in other parts of this document, there is a general hesitancy in Idaho to expand Medicaid. Idaho, along with other states, is wrestling with difficult issues of how to control costs in the overall Medicaid program. In addition, Medicaid is sometimes viewed by the providers and the public as being overly bureaucratic (Report to the Director, Idaho Department of Health and Welfare from; The Children's Health Insurance Program Task Force, Delivered: November 16, Pg. 6). Because of these feelings, the original Idaho CHIP task force recommended that Idaho adopt a state-administered program. Careful review of this recommendation indicated that at this juncture because of federal requirements and the 10 percent administrative cap on state-run program such an approach would not be cost effective *(Attachment #7*). We continue to believe that a state-only program might have merit if it could be demonstrated to be cost effective. We also believe that significant work needs to be undertaken at the federal level to review the basic image of the Medicaid program and eliminate bureaucratic barriers wherever possible in the Medicaid program design. One example is the completion of this report. Small states like Idaho have limited staff that must be responsible for both program implementation and federal reporting. A report of this nature while providing valuable information is just one example of the types of federal reporting requirements that put tremendous strain on the resources available in small programs.

- **Lift the 10% cap on administrative costs for state-administered programs**

As noted above, Idaho stakeholders were interested in designing their own state-administered program. Careful analysis of this option indicated that it would not be possible to design the program and operate it within the 10 percent cap. Thus, this option was effectively taken off the table. We believe that states have many creative ideas around CHIP which should be encouraged through broad flexibility in program design and federal sharing of both administrative and services costs.

- **Review options for helping states move to the 200% of poverty level using graduated approaches.**

The current Idaho CHIP eligibility is established at 150 percent of the Federal Poverty level (FPL). Members of the original task force were interested in providing eligibility to 200 percent of poverty. Specifically the task force recommended a graduated voucher system to help families systematically become self-reliant from the CHIP program as their income increased. Federal rules prevented such an approach. We still believe that the Federal government should help states review a variety of options which might expand health insurance services to children while also retaining parental involvement in the cost of providing that insurance as income rises.

In conclusion, we would like to re-emphasize our state's commitment to improving the health outcomes of the children who live within our borders and in this country. We believe we have designed an approach to CHIP, which is both innovative and effective. We would be happy to provide technical assistance to any state wanting to know more about our program.

ATTACHMENT #1
TITLE XXI PLAN AMENDMENT

AMENDED
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: IDAHO
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

Karl B. Kurtz, Director — Date

submits the following amended State Child Health Plan for the State Children's Health Program and hereby agrees to continue to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete

and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

1.1. ☐ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan **(Section 2103)**; **OR**

1.2. ☑ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.3. ☐ A combination of both of the above.

Idaho's vision for the Children's Health Insurance Program:

To provide basic healthcare to uninsured children who are at or below 150% of the Federal Poverty Level through enrollment in Title XIX or XXI.

Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

GEOGRAPHY: Idaho is a predominantly rural state. It has approximately 1.2 million people and is ranked 40th in the nation for population. It also occupies a land area of 83,557 square miles and is the thirteenth largest state in area. Additionally, Idaho has diverse geology and biology containing large areas of alpine mountainous regions, vast desert plains, farmland valleys, and deep canyons and gorges. Many areas of the state have few roads. Some areas are vast wildernesses with no roads. Only two out of 44 counties meet the criteria of a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget. The remaining counties are classified as rural (6 people per mile) or frontier (less than 6 people per square mile). Thirty-six percent of Idaho's population resides in these rural and frontier counties. Sixteen of Idaho's counties are considered frontier. These frontier areas comprise 59% of Idaho's total land area. Two-thirds of Idaho's landmass consists of state and federal public lands. The rural nature of Idaho has a significant impact on health care issues, including insurance enrollment and health access.

GENERAL POPULATION: From April 1, 1990 to July 1, 1997, Idaho's population increased from 1,006,749 to 1,210,232 or 20% (an average rate of 2.5% annually), the third-highest increase in the nation. Three-fourths of the population growth has occurred in urban areas, especially Ada, and Canyon Counties in southwest Idaho and Kootenai County in northern Idaho. That growth has continued and is expected to be reflected in the 2000 census data.

Racial Demographics: According to 1998 projections using the 1990 census data, 97% of Idaho's population is white (Persons of Hispanic heritage are included in this number). The racial composition of the remaining 3% of Idaho's population is as follows:

African American	Native American	Asian/Pacific Islander	Other	Total % Population
.5%	1.3%	1.1%	.1%	3%

Ethnic Demographics: Idaho's largest ethnic minority, representing 7.1% of the state's total population, is of Hispanic heritage. Southwest and south central Idaho especially have large concentrations of people with Hispanic heritage. Up to 15% of these two region's total population is of Hispanic heritage and culture. Idaho also has five

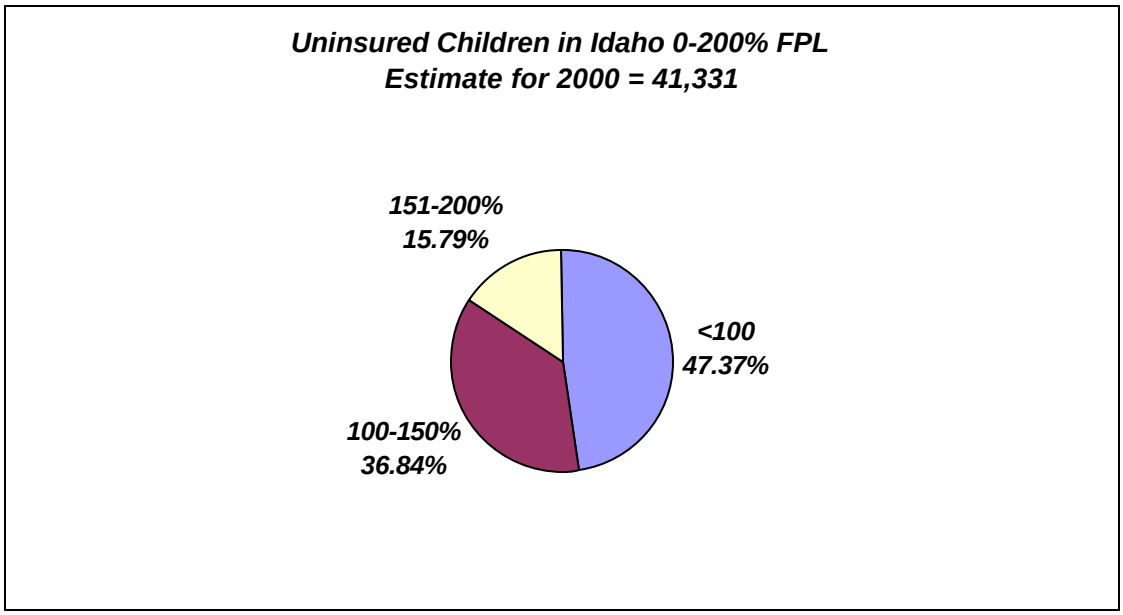
Native American tribes: the Shoshone and Bannock Tribes in eastern Idaho, the Shoshone and Paiute Tribes in Duck Valley, southwestern Idaho, the Nez Perce Tribe in north central Idaho, and the Coeur d'Alene Tribe in northern Idaho. Total tribal membership in Idaho is estimated at 15,750.

CHILD POPULATION: Estimates of the number of children in Idaho and the number of uninsured children have been developed from 1990 Census data, Census Bureau Current Population Survey data, and data developed for the Casey Foundation through the University of Louisville. From these sources, the estimate of the number of children in Idaho in 2000 is 399,167. Of those, 192,515 children live in families with incomes at or below 200% of the Federal Poverty Level. Of those children, Idaho estimates that 41,331 are without health insurance. Of all children, there are an estimated 59,821 who are uninsured, or 15% of the total.

CHILDREN POPULATION AND INSURANCE DATA: YEAR 2000

FPL	Children	Children w/o insurance	% w/o insurance	Children w/o insurance cumulative	
<100%	76,135	19,578	26%	19,578	
101-124%	31,542	8,701	28%	28,279	
125-149%	26,104	6,526	25%	34,805	Idaho target
150-174%	29,367	3,263	11%	38,068	
175-199%	29,367	3,363	11%	41,331	Federal target
22-249%	47,857	5,438	11%	46,769	
250+%	158,797	13,052	8%	59,821	
Total	399,167	59,821	15%		

The 1998 Idaho Legislature reviewed the Children's Health Insurance Program and set the upper limit for eligibility at 150% of the Federal Poverty Level. At that level, Idaho estimates that there are 34,805 uninsured children potentially eligible for either Medicaid Title XIX or CHIP Title XXI health insurance. That number represents 79% of the estimated number of uninsured children in Idaho and 84% of the uninsured children potentially eligible for CHIP under the federal standard.

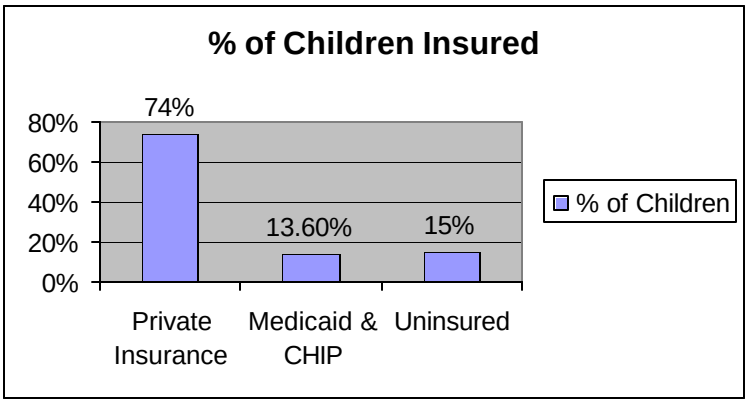


In addition to the estimates on the number of uninsured children in Idaho, the Department of Health and Welfare has data on actual enrollment of children in Title XIX and Title XXI programs from July, 1996 to September, 1999. Those figures indicate that a total of 54,172 children are enrolled in these programs. That figure represents 13.6% of all children and 40.5% of all children at or below 150% of the Federal Poverty Level.

HISTORICAL MEDICAID ENROLLMENT DATA

CHILD MEDICAID ENROLLEES (7/96)		42,765	
PRE-CHIP CHILD MEDICAID ENROLLEES (9/97)		37,013	
	TITLE XIX	TITLE XXI	TOTAL
CURRENT MEDICAID/CHIP ENROLLEES (9/99)	50,437	3,735	54,172
ENROLLMENT INCREASE SINCE 9/97	13,424	3,735	17,159

In 1996, the best estimate of insurance coverage for Idaho children projected that 13.2% of the children were uninsured, 19.8% were enrolled in Medicaid, and 74.2% had some form of private insurance during the year. These numbers add up to more than 100% because some children were counted in more that one category during the year. Census Bureau data for 1998 estimate at a national level that 15.4% of children were uninsured, 19.8% were covered by Medicaid, and 67.5% had private coverage. The 1999 Idaho data indicate 15% of children are uninsured, 13.6% of children are covered by Medicaid, and, extrapolating, 74% of children are covered by private insurance. These estimates approximate the 1998 Census Bureau national data on percentages of children insured.



To estimate the number of uninsured children who are potentially eligible for the Title XXI Children's Health Insurance Program, the Department started with the 34,805 uninsured children at or below 150% of FPL. Based upon enrollment experience and the percentages of children who are eligible through the Pregnant Women and Children Program and other Title XIX programs, the Department is estimating that 25% of the target population could be enrolled in CHIP. That number amounts to 8,701 children.

In 1999, the Department of Health and Welfare, with the endorsement of Governor Kempthorne, made the decision to continue operation of CHIP as a Medicaid expansion and coordinate all enrollment efforts between CHIP and Medicaid. DHW developed a unified approach to CHIP implementation using a single message, streamlined application, and outreach/education effort targeted all uninsured children at or below 150% of FPL. This approach is designed to make it easy for families to apply for and have their children enrolled in either program in a customer friendly, seamless manner. Annualization of income, self-declaration of income and assets, and 12-month continuous eligibility for both programs enhances the opportunity to enroll uninsured children. Significant partnerships have been developed with national and state businesses, health providers, and community agencies to promote CHIP.

The 1999 Idaho Legislature authorized a legislative interim committee to review the levels of uninsured families in Idaho and develop a set of recommendations on how to make insurance more affordable and available to Idaho residents. That committee is to present its recommendations to the 2000 Legislature. Its goal is to identify financial, business, legislative, and taxation strategies that would make it more feasible for uninsured individuals to become insured.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

This section of the plan describes the structure DHW has established to facilitate program coordination across the umbrella agency and enrollment activities designed to increase Idaho children's enrollment in public health insurance programs. A description of the state's outreach

efforts through the Medicaid and state-only program are presented in Section 5.1. Enrollment and outreach activities are designed to be complimentary functions.

CHIP Process and Structure

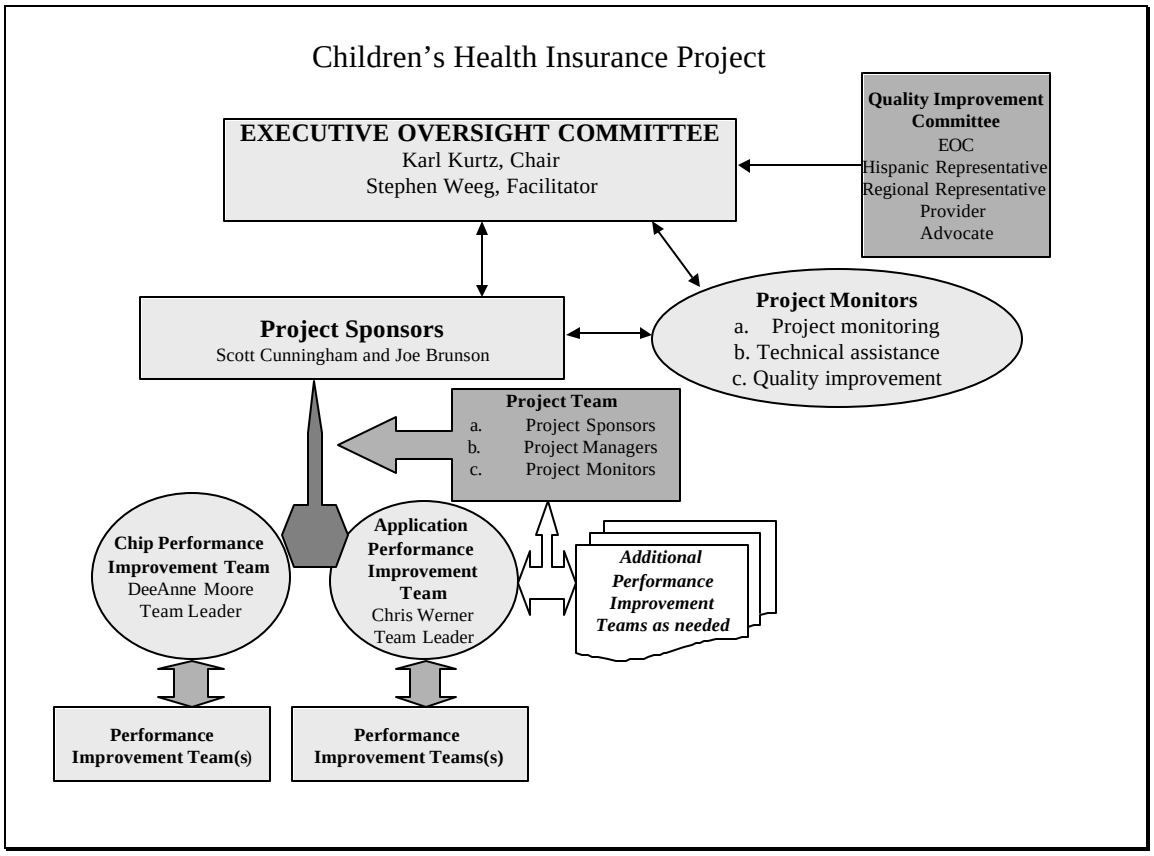
The Idaho Department of Health and Welfare (DHW) is an umbrella human services organization. DHW has direct responsibility for child protection, child abuse prevention, health, Medicaid, family cash and other subsidy income supports, developmental services, and mental health and substance abuse services. DHW staff includes line personnel in each of these areas who have daily contact with children and families as well as regular contact with community leaders.

DHW recognizes that it would not be possible to reach this large number of potential enrollees through a single Division. Rather DHW envisions CHIP as an ongoing sustainable outreach, insurance enrollment and service provision process.

The large size of the project requires a coordinated effort across DHW divisions and the development of a strong partnership with Regional Field Offices and other stakeholders to achieve this goal. DHW has established the sustainable structure that insures coordination of activities at both the state level and regional levels. This structure is described in more detail below.

State Level Coordination

In order to insure ongoing coordination of activities throughout the DHW, an executive oversight committee responsible for overall project direction and quality improvement activities has been established. Specific project tasks are the responsibility of project teams with appropriate representation from throughout the Department and other affected stakeholders. The table on the page 9 presents the Department Organization for CHIP. The Enrollment Performance Improvement Team, led by staff from the Welfare Division, is responsible for designing and implementing all enrollment changes. The CHIP Performance Improvement Team led by staff from the Medicaid Division is responsible for designing and implementing the Outreach and Education portions of the access pathways.



DHW is in the process of establishing a CHIP Resource Network. This network, to be established in FFY 2000, will be linked by email and the Web to insure that all participants have the latest information on CHIP. The Resource Network is broadly based and includes both DHW staff and stakeholders:

Internal Stakeholders

- Office of Public Participation
- State WIC program
- Governor's Office
- Idaho CareLine
- Division Administrators and appropriate staff
- County Welfare Staff
- Self-reliance Specialists
- Out-stationed Eligibility Workers
- Regional Directors

External Stakeholders

- Pediatric/Family Health Care Providers
- Idaho Hospital Association
- Immunize-by-Two Coalition
- Idaho Perinatal Project
- Community/Migrant Health Centers
- Director of the Idaho Robert Wood Johnson Covering Kids project and staff
- The Idaho Robert Wood Johnson Covering Kids Coalition
- Culturally diverse and under-served populations
- State schools
- State Head Start program
- Parish nursing coordinator
- Pharmaceutical companies
- County Welfare
- Salvation Army

Following a continuous quality improvement model, DHW has also established a Quality Improvement Committee composed of the Executive Oversight Committee and representatives of the medical community, advocacy groups, public health and Head Start. The purpose of the Committee is to monitor the Department's performance in implementing Children's Health Insurance and to provide guidance in areas where performance can be improved.

Innovations in Application Assistance and Enrollment

DHW also has implemented a number of initiatives designed to be customer friendly and provide potential enrollees with application assistance and thus enhanced enrollment. The activities below reflect only those activities undertaken by the DHW with DHW resources. Activities involving enrollment but based on public/private partnerships are contained in 2.2.2. These initiatives include but are not limited to:

- Idaho CareLine—an 800 number providing referral assistance to DHW customers throughout Idaho. The Idaho CareLine has a direct link to CHIP assistance. CHIP makes up the largest segment of callers on a regular basis. 888 KIDS NOW connects directly to the Idaho CareLine
- Benefits for Working Families—a brochure outlining the services available throughout DHW to families

- Provisions of Spanish Speaking DHW staff in all regions—Idaho's largest minority group are Hispanics. DHW has made an effort to ensure that all materials are in Spanish and that Spanish Speaking staffs are available in the local offices
- Provision of customer satisfaction forms in all offices as well as follow-up on customer satisfaction after a final determination has been made.
- Provision of mail/fax in applications—the redesigned application allows potential CHIP enrollees to submit their application by mail or fax. Eligibility workers can make a CHIP eligibility determination without a personal visit. When information is missing, self-reliance workers are to contact potentially eligible families by telephone.
- Contracting for out-stationed eligibility workers—DHW has contracted with the Idaho Primary Care Association to make out-stationed eligibility workers available at Federally Qualified Health Centers (FQHC). These workers focus on providing both application assistance and outreach. All out-stationed eligibility workers are bilingual.
- Expanded enrollment assistance through alternative public sites--DHW is in the process of working with the public health agencies throughout the state to establish a process in which applicants for public health services such as Maternal and Child Health Block Grant, Title V, and WIC will receive immediate assistance in applying for CHIP.
- Coordinated outreach and enrollment activities with the Idaho Department of Education and school lunch and child care food programs.
- Coordinated outreach activities with the Idaho Hospital Association as described in Section 2.2.2.

Changes in Policy Designed to Increase Enrollment

As part of its efforts to significantly increase enrollment of eligible children, DHW under the direction of Karl Kurtz undertook a fast-track redesign of the Application for Assistance. The redesigned form is four pages long and is used for all benefit programs in the Self-Reliance Program (Health Coverage, Cash Assistance, Food Stamps, Child Care, Telephone Service and Nursing Home). As part of the forms redesign process, DHW implemented a number of new policies designed to improve enrollment. These policies are as follows:

- Establishment of a 12-month continuous eligibility period for children.
- Redesign of Application from case-centered to person-centered.
- Self-declaration of income and assets for health coverage for families and children.
- Annualize income for enrollment. This policy was adopted to assist seasonal or temporary workers. In some cases, the bulk of a workers' income may be earned during a time-span of three to four months.
- Elimination of the requirement for proof of citizenship from non-applicants.

2.2.2 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Idaho has been actively involved in creating an array of public/private partnership to increase enrollment of children in health insurance programs. These activities include the following:

- Provision of Application Assistance in areas of high utilization by potential enrollees
    - DHW has contracted with the Idaho Primary Care Association to provide additional application assistance to potential eligible in locations where participants have a high likelihood for being eligible for assistance, such as Migrant Center and Community Health Centers.
    - DHW is in the process of working with the Idaho Hospital Association so that hospital admitting units, billing offices and emergency rooms are able to provide application assistance.

- Work with Mountain States Group, a private non-profit corporation, in developing and implementing a successful proposal for funding through The Robert Wood Johnson Foundation Covering Kids Initiative to increase enrollment of uninsured children in health insurance programs.
    - DHW staff worked with Mountain States Group staff on the initial application for Covering Kids funding from The Robert Wood Johnson Foundation.
    - DHW staff participates on the Covering Kids Coalitions at the statewide level and in the project's two pilot communities.
    - DHW staff is working with the Mountains States Group to match certain Robert Wood Johnson Foundation funds with Medicaid funds in order to enhance the funding available to this project for outreach activities.
    - DHW's CHIP Outreach Coordinator and the Covering Kids Director meet regularly to coordinate outreach efforts.
    - DHW staff have engaged in joint outreach efforts with Covering Kids staff at the state and regional levels.
    - The Covering Kids Director serves on the DHW CHIP Quality Improvement Committee.

2.3 Describe how the new State Title XXI program is designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:
(Section 2102)(a)(3)

The Idaho Department of Health and Welfare (DHW) began enrolling children in Idaho Children's Health Insurance Program (CHIP) in October 1997. The Health Care Financing Agency (HCFA) approved the state plan in June 1998, as a Medicaid expansion program. At the program approval time, eligibility for the program included children 0-19 years of age with no credible health insurance coverage and with a family income below 160% of the Federal poverty limit. The Idaho Legislature changed the income eligibility to 150%, effective July 1998.

When the federal government developed the CHIP program (Title XXI), CHIP terminology referred to a categorical health insurance program for children whose family's income was above traditional Medicaid eligibility (Title XIX) and below the eligibility cap established by each state's legislature (in Idaho's case 150% of poverty).

As part of the process of developing a comprehensive program to insure Idaho's low income children and based on Idaho and national experience, it has become clear that a comprehensive effort to enroll Idaho's uninsured children in CHIP will also impact the Medicaid program. Thus, DHW leadership has determined that CHIP in Idaho will be the name used to refer to a comprehensive approach to providing health insurance, to all potentially eligible children below 150% of poverty. This approach includes both Title XIX (Medicaid) and Title XXI (Federal CHIP) children. The Idaho CHIP program is designed to ensure that the category of federal funding is invisible to the enrollee, but trackable for executive policymaking and legislative purposes. As described in Section 2.2.1 every effort has been made to create an administrative structure for CHIP that enhances enrollment of children in health insurance.

Through the single application process, all children are first reviewed for Title XIX eligibility. Those that are found eligible are enrolled in Title XIX. Those who are ineligible for Title XIX and meet the income standards for Title XXI are considered for Title XXI enrollment. The application requests information from the applicant to determine if s/he has other creditable health coverage.

Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))

☑ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: **(Section 2102)(a)(4)**

_____

3.2. Describe the utilization controls under the child health assistance provided under the
plan for targeted low-income children: **(Section 2102)(a)(4)**

_____

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

☑ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A))**

4.1.1. ☐ Geographic area served by the Plan:_____

4.1.2. ☐ Age:_____

4.1.3. ☐ Income:_____

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):_____

4.1.5. ☐ Residency:_____

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): _____

4.1.7. ☐ Access to or coverage under other health coverage:_____

4.1.8. ☐ Duration of eligibility _____

4.1.9. ☐ Other standards (identify and describe): _____

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B))**

4.2.1. ☐ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2))**

_____

4.4. Describe the procedures that assure:

4.4.1. Through intake and followup screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A))**

_____

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. **(Section 2102)(b)(3)(B))**

_____

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. **(Section 2102)(b)(3)(C))**

_____

4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). **(Section 2102)(b)(3)(D))**

_____

4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. **(Section 2102)(b)(3)(E))**

_____

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))

Idaho views outreach to families of children likely to be eligible for assistance as a two-pronged process of outreach/education. These activities are defined as follows:

Outreach: Activities targeted toward informing and motivating potentially eligible families to apply for health care coverage.

Education: The process of giving individuals and organizations who come into contact with low-income children information on health care coverage options.

Outreach and education activities are those administrative procedures and program features that inform and recruit children and their families into potential enrollment. Outreach activities are associated with a set of complex procedures in which families interact with state and local government agencies, advocacy groups, and other organization involved in outreach (Halfon, et al, Milbank Quarterly, 1999, p. 189). In other words, Idaho does not view quality outreach as synonymous with public relations. General media activities are an important component of a quality outreach plan but media is certainly not the only component and depending on the population to be reached may not be the most effective component.

Halfon, et al, have identified a number of critical factors leading to successful outreach. These factors are:

- Targeting
- Appropriate Message and Type for Targeted Group(s)
- Location of Outreach Activities for Targeted Group(s)
- Appropriate Media and type for Targeted Group(s)
- Cultural/Language Considerations for Targeted Groups(s)

DHW has determined that to reach the target group families, education should be directed to the following groups:

- Schools
- Culturally Diverse Groups
- HeadStart/Child Care Providers
- Maternal Child Health Programs
- Health Care Providers
- Child Advocacy Groups

Idaho has developed a multi-dimensional approach to outreach including but not limited to:

- Building on existing regional successes through emphasis on targeted, grass-roots outreach.
- State level coordination across all DHW Divisions. The state level has an internal project work team with representatives across DHW described in Section 2.2.
- Establishment of a virtual resource network for CHIP. Membership will include all planning partners from throughout Idaho. The network will provide for ongoing dialogue and collaboration about program direction.
- Supporting regional efforts through a statewide public relations effort and professionally designed promotional materials
- Provision of technical assistance to regional efforts through outreach support teams
- Provision of funding to assist in implementing regional plans through community outreach grants. DHW has earmarked a minimum of $225,000 for community outreach. These funds are available to regions to help reach targeted groups defined in the regional plans. Regional planning teams will solicit and select applicants using the model RFP designed by the CHIP Performance Improvement Team. Contracts for services will be with the Region and the selected provider.
- Using Vista Volunteers. Regional Directors can request a VISTA Volunteer. Medicaid will provide the necessary funds to provide the match to the Americorps contribution. Vista workers will be used for CHIP community outreach and education efforts. This program would be modeled after the nationally recognized Idaho VISTA immunization project

Regional activities are based on a regional plan. The plan is developed and implemented under the direction of the Regional Director with the assistance of Healthy Connection Staff. The Healthy Connections staff is part of the Division of Medicaid but located in regional offices. The staff has primary responsibility for Medicaid's Primary Care Case Management Program. The planning process is intended to bring interested stakeholders to the table to share ideas and enhance coordination of outreach/education/enrollment for CHIP throughout the region. The regional plan includes at a minimum:

- Targeted groups for the region
- Message and approach for reaching each group including strategic outreach partners i.e. schools, HeadStart, WIC
- Potential partners to assist enrollees in completing applications i.e. hospitals, primary care clinics
- Priorities for community outreach grants
- Potential business partners and recruitment strategy to involve these partners
- Potential staff resources

The grassroots/regional activities are being supported by media activities. DHW has established a media contract to provide professional assistance in the design and implementation of the CHIP media campaign. Media activities include but are not limited to:

- A standard logo
- New posters in both Spanish and English
- Business cards in English on one side and Spanish on the other
- Television advertisements. The ads started in February 2000 with a rotating schedule over the next two years
- CHIP phone number will be in all Idaho telephone directories under government, business, & in yellow pages
- A Spanish language outreach component will be developed and will include Novellas on Spanish radio, Spanish print ads, and Spanish radio spots
- Prices of billboards are being investigated
- Underwriting a children's public television show is being considered
- CHIP decals, stickers, & buttons will be available in the spring
- Radio ads targeted to mothers and fathers emphasizing working parents in the 21-34 age bracket will be aired in the spring

5.2 Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

- DHW is working to encourage coordination of the CHIP program with other public and private health insurance programs through shared outreach/educational activities. Coordination in this area parallels the activities described in Section 2.2 on coordination of enrollment activities. Thus, for the sake of brevity will not be reiterated here.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☑ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.)

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1))**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.) _____

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.) _____

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2))** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4)**. See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3))** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."

_____
_

6.1.4. ☐ Secretary-Approved Coverage. **(Section 2103(a)(4))**

6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a))**

6.2.1. ☐ Inpatient services **(Section 2110(a)(1))**

6.2.2. ☐ Outpatient services **(Section 2110(a)(2))**

6.2.3. ☐ Physician services **(Section 2110(a)(3))**

6.2.4. ☐ Surgical services **(Section 2110(a)(4))**

6.2.5. ☐ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. ☐ Prescription drugs **(Section 2110(a)(6))**

6.2.7. ☐ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. ☐ Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. ☐ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. ☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11. ☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12. ☐ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13. ☐ Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. ☐ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15. ☐ Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. ☐ Dental services **(Section 2110(a)(17))**

6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. ☐ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. ☐ Case management services **(Section 2110(a)(20))**

6.2.21. ☐ Care coordination services **(Section 2110(a)(21))**

6.2.22. ☐ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23. ☐ Hospice care **(Section 2110(a)(23))**

6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☐ Medical transportation **(Section 2110(a)(26))**

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: **(Section 2105(c)(2) and(3))**

6.3.1. ☐ **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** **(Section 2105(c)(2)(B)(i))**

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii))**

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** **(Section 2105(c)(2)(B)(iii))**

6.3.2. ☐ **Purchase of Family Coverage.** Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3))**

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A))**

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B))**

Section 7. Quality and Appropriateness of Care

☑ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A))**

_____

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards

7.1.2. ☐ Performance measurement

7.1.3. ☐ Information strategies

7.1.4. ☐ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. **(2102(a)(7)(B))**

_____

Section 8. Cost Sharing and Payment **(Section 2103(e))**

☑ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. ☐ YES

8.1.2. ☐ NO**, skip to question 8.5.**

8.2. Describe the amount of cost-sharing and any sliding scale based on income: **(Section 2103(e)(1)(A))**

8.2.1. Premiums:_____
8.2.2. Deductibles:_____
8.2.3. Coinsurance:_____
8.2.4. Other:_____

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: _____

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: **(Section 2103(e))**

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B))**

8.4.2. ☐ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2))**

8.4.3. ☐ No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. ☐ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4))**

8.4.5. ☐ No premiums or cost-sharing will be used toward state matching requirements. **(Section 2105(c)(5)**

8.4.6. ☐ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A))**

8.4.7. ☐ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1))**

8.4.8. ☐ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B))**

8.4.9. ☐ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: **(Section 2103(e)(3)(B))**

_____

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

8.6.1. ☐ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

8.6.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2109(a)(1),(2))**. Please describe:

_____

Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)

Introduction

The state of Idaho has developed a set of strategic objectives, performance goals, and performance measures to assess the success of implementing its Medicaid Children's Health Insurance Program. These measures are designed to measure the effectiveness of both Title XIX and Title XXI Programs. The objectives, goals, and measures focus on standard indicators of success in enrollment and retention and in basic health outcomes. The measures have been developed based upon data that is readily available to the Department of Health and Welfare. Idaho has not implemented HEDIS 3.0, so information through that means is not available.

Idaho will track enrollment, retention, access, comprehensiveness, and quality of care. All performance measures will be linked to performance standards and strategic objectives.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2))

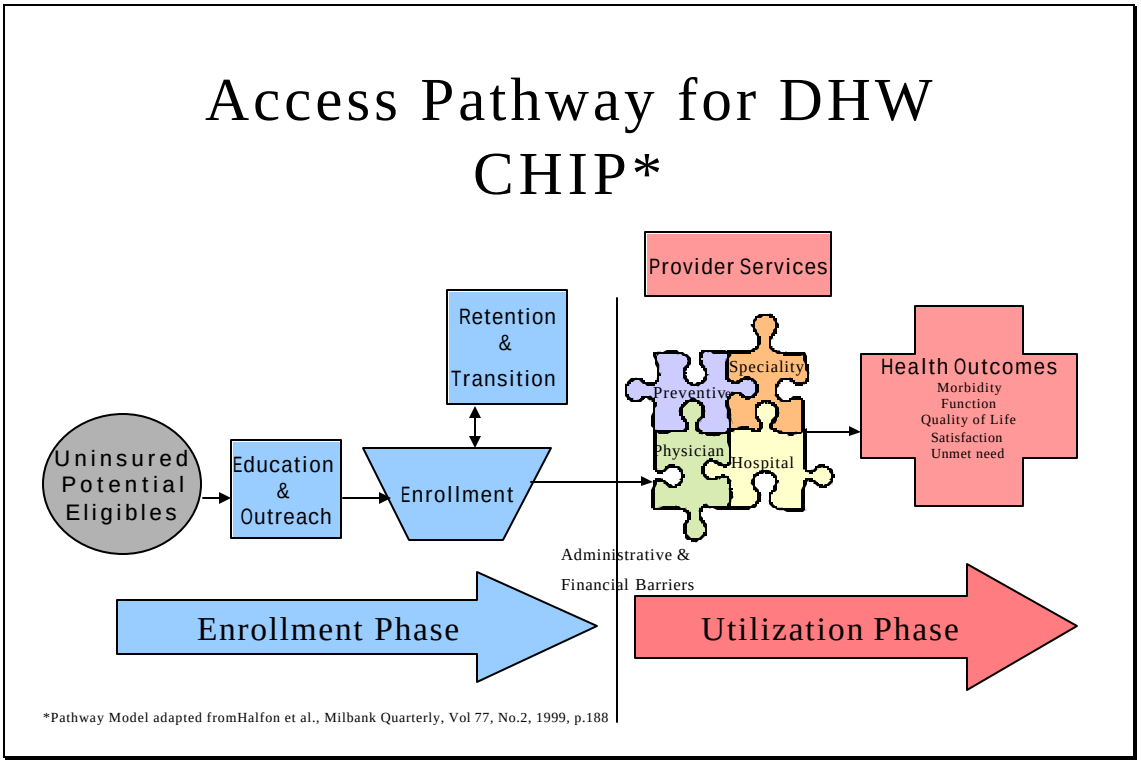
Strategic objectives are listed in Table 9.1

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))

Performance goals are listed in Table 9.1

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B))

Idaho has approached CHIP implementation as a comprehensive process with two major components: 1. Outreach (as described throughout this proposal) and 2. Health Care Access. Figure 9.0 presents an overview of this process.



Performance measures to successfully implement this system are listed in Table 9.1

Table 9.1 provides a clear picture of the strategic objectives, performance goals, and performance measures and the data elements proposed to measure them. The strategic objectives may have more than one goal. Each goal has a performance measure and a corresponding set of measurable data elements. A baseline will be established for each measure. In most cases, the baseline will be an assessment of that measure in the Title XIX program prior to implementation of the Children's Health Insurance Program, Title XXI.

Table 9.1

Quality Table **Strategic Objectives, Performance Goals and Measures, and Data Elements**			
Strategic Objectives	Performance Goals	Performance Measures	Data Elements
To enroll 35,000 uninsured children (10/99 estimate) in Title XIX and XXI health programs.	The targeted increase in the enrollment of uninsured children: FY 2000: 8,000 FY 2001: 8,000 FY 2002: 8,000 FY 2003: 8,000	Annual increase in enrollment of uninsured children in both programs compared to the previous federal fiscal year. The total number of new uninsured children enrolled in both programs compared to the base number of enrollees as of 9/30/97	Baseline child Medicaid enrollees as of 9/30/97. Annual new enrollees in both Title XXI and XIX.
To design and implement a sustainable, community-based education and outreach program.	State level and regional outreach and education plans are developed and implemented by 12/31/00. Applications and application assistance are available to target groups in a minimum of 75% of Head Start, WIC, and Migrant and Community Health sites and 90% of birthing hospitals, with a total of at least 5 sites per region, one of which is a school, by 12/31/00.	Locations other than DHW field offices having applications. Locations providing application assistance. Involvement of target groups and agencies in outreach and education activities.	Number of locations where applications and application assistance is available. Number and type of state and community partners. Outreach grant recipients and grant activities. Regional and state outreach and education plans

Quality Table **Strategic Objectives, Performance Goals and Measures, and Data Elements**			
Strategic Objectives	Performance Goals	Performance Measures	Data Elements
To simplify and streamline the application and enrollment process.	The application will be customer friendly, 4 pages long, & only request minimum required information by 12/31/99. Applications can be mailed and children enrolled without a required interview by 12/31/99. Results of the customer surveys will be used to make adjustments as indicated by 12/31/00.	A shortened application is implemented. The % of applications processed without an interview. Results of customer satisfaction surveys	Difference in length of new and old forms. Total number of applications processed and number processed without interview. Satisfaction surveys
To retain enrolled children in Title XXI and XIX programs.	Increase in mean and mode length of enrollment of at least 1 month in each of the next three fiscal years for Title XXI participants.	Average length of enrollment for children in these programs.	Baseline: 6 mo. mean 2 mo. mode Enrollment period per child and mean and modal lengths of enrollment per fiscal year.

Quality Table **Strategic Objectives, Performance Goals and Measures, and Data Elements**			
Strategic Objectives	Performance Goals	Performance Measures	Data Elements
To ensure that enrolled children have a medical home.	There will be a 10% annual increase in the number of children participating in Healthy Connections and having a primary care provider as a "medical home".	Baseline % of children participating in Healthy Connections. Rate of enrollment of children in Healthy Connections. Number and percentage of physicians participating in Healthy Connections.	Number of children enrolled in Healthy Connections compared to total CHIP enrollment Number of participating physicians compared to total possible pool.
To ensure that enrolled children receive appropriate and necessary medical care.	90% of enrolled children will have up-to-date, age-appropriate vaccinations. 80% of enrolled children age 12 months and younger will have received appropriate preventive care.	Percentage of enrolled children who have up-to-date, age-appropriate vaccinations. Percentage of enrolled children who have received appropriate preventive care. Percentage of enrolled children who access health care compared to national data.	EPSDT screening data Percentage of enrolled children who use services in Idaho and nationally
To implement a quality improvement process for children's health.	Preferred health outcomes and care management strategies for children will be identified by 12/31/00.	List of health outcomes and care management strategies adopted.	Dependent upon outcomes and strategies adopted.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☑ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☑ The reduction in the percentage of uninsured children.

9.3.3. ☑ The increase in the percentage of children with a usual source of care.

9.3.4. ☑ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

Governor Kempthorne has established a goal of 90% immunization rate for children. Liz Trias, HCFA Region X, Health Insurance Specialist A central registry is being established to track immunization rates. Data from this registry will be used to monitor achievement of strategic objectives in this plan.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. ☐ Immunizations

9.3.7.2. ☐ Well child care

9.3.7.3. ☐ Adolescent well visits

9.3.7.4. ☐ Satisfaction with care

9.3.7.5. ☐ Mental health

9.3.7.6. ☐ Dental care

9.3.7.7. ☐ Other, please list: _____

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☑ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1))**

9.5. ☑ The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10)

Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2))**

The State assures it will comply with the annual assessment and evaluation required under Sections 10.1 and 10.2. The assessment will be built upon the data obtained to monitor the achievement of the strategic objectives listed in Table 9.1.

The annual assessment will calculate enrollment increases in both Title XIX and XXI programs and the estimated impact of these increases on the number of uninsured children in Idaho. Effectiveness will also be measured by how close the program comes to meeting the performance goals detailed in Section 9 using the performance measures and data elements identified in Table 9.1. Idaho has implemented a CHIP Quality Improvement Committee which will meet quarterly to monitor program performance and to identify trends and changes that may impact program effectiveness.

9.6. ☑ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3))**

9.7. ☑ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e))**

9.8.1. ☑ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☑ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☑ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☑ Section 1115 (relating to waiver authority)

9.8.5. ☑ Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI

9.8.6. ☑ Section 1124 (relating to disclosure of ownership and related information)

9.8.7. ☑ Section 1126 (relating to disclosure of information about certain convicted individuals)

9.8.8. ☑ Section 1128A (relating to civil monetary penalties)

9.8.9. ☑ Section 1128B(d) (relating to criminal penalties for certain additional charges)

9.8.10. ☑ Section 1132 (relating to periods within which claims must be filed)

9.9.1. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c))

Idaho has involved key stakeholders in the design, review, and implementation of its Children's Health Insurance Program.

In 1998, then Governor Batt convened a task force charged with the responsibility to review and make recommendations on the operation of the Children's Health Insurance Program. That task force included legislators, consumers, advocates, healthcare providers, business and insurance entities, and low-income agencies. It made a series of recommendations in late 1998.

In 1999, Governor Kempthorne became Governor and asked for a review of the Task Force recommendations. The Department of Health and Welfare convened a Steering Committee to make recommendations on program implementation. That group, along with a Department CHIP Executive Oversight Committee, agreed upon a set of activities to increase outreach and enrollment and to maintain CHIP as a Medicaid expansion. The Steering Committee included representatives from the Task Force and additional community and Department representatives. Once the Steering Committee completed their recommendations, the committee work was concluded.

The Department has convened a Quality Improvement Committee comprised of Department executive staff and key community members to monitor program implementation on a quarterly basis and to make recommendations for improvement. Community members are also involved in the development and implementation of regional outreach and education plans.

The Department is committed to working with its community partners in the design, implementation, and review of this program. It has, and will continue to, solicit and receive community input from all key constituents in order to make the program succeed.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

The budget for this program in state fiscal year 1999 was $4,436,081. The revenue for the non-Federal share, $887,216 came from state general funds appropriated by the Idaho Legislature. The average monthly number of children enrolled in Title XXI was 3,100 at an average cost of 108.41 per month per enrollee. Through aggressive outreach the Title XXI program is enrolling more uninsured children and Idaho projects that during FFY '01, the average monthly enrollment will be 7,250 children. Using the current monthly cost per enrollee, Idaho projects that the budget for FFY '01 will be $10,374,837. 10% of the budget is allocated to administrative costs and 90% is allocated to services.

To estimate the cost of itemized services for FFY'01, the actual costs by service category in SFY 99 were used as a basis. Then, the percentage for that category of the total cost of services was figured. That percentage was used to estimate the potential cost per service category for FFY '01.

Table 9.2 illustrates the actual and proposed budgets.

Table 9.2

Title XXI Budget	**SFY 99 Actual**	**% of Total**	**FFY 01 Projected**
Average enrollees/month	3100		7250
Average cost/enrollee/month	$108.41		$108.41
Revenue	$ 4,436,081.00		$ 10,374,837.00
Administration	$ 403,280.00		$ 943,167.00
Services	$ 4,032,801.00		$ 9,431,670.00
Expenses by category			
Inpatient Hospital	$ 810,057.00	20.09%	$ 1,894,512.10
Inpatient Mental Health	$ 217,265.00	5.39%	$ 508,126.18
Physician & Surgical Services	$ 748,216.00	18.55%	$ 1,749,882.13
Outpatient Hospital	$ 324,897.00	8.06%	$ 759,849.37

Prescribed Drugs	$ 412,102.00	10.22%	$ 963,799.12
Dental Services	$ 618,086.00	15.33%	$ 1,445,541.99
Other Practitioners	$ 185,006.00	4.59%	$ 432,680.79
Clinic Services	$ 314,106.00	7.79%	$ 734,612.03
Laboratory & Radiology	$ 112,867.00	2.80%	$ 263,966.48
Family Planning	$ 27,457.00	0.68%	$ 64,214.76
Screening Services	$ 36,474.00	0.90%	$ 85,303.18
Home Health	$ 9,110.00	0.23%	$ 21,305.91
HCBS	$ 15,189.00	0.38%	$ 35,523.11
Medical Transportation	$ 46,760.00	1.16%	$ 109,359.45
Case Management	$ 30,888.00	0.77%	$ 72,238.98
Other Services	$ 124,321.00	3.08%	$ 290,754.40
Grand Total	$ 4,032,801.00	100.00%	$ 9,431,670.00

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2))**

10.1.1. ☑ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2. ☑ Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

Attributes of Population	Number of Children with Creditable Coverage XIX OTHER CHIP	Number of Children without Creditable Coverage	**TOTAL**
Income Level:			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
Age			
0 – 1			
1 – 5			
6 – 12			
13 – 18			
Race and Ethnicity			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			
Hispanic			
White, not of Hispanic origin			
Location			
MSA			
Non-MSA			

10.2. ☑ State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: **(Section 2108(b)(A)-(H))**

10.2.1. ☑ An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1. ☑ The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

10.2.2.2. ☑ The quality of health coverage provided including the types of benefits provided;

10.2.2.3. ☑ The amount and level (including payment of part or all of any premium) of assistance provided by the state;

10.2.2.4. ☑ The service area of the state plan;

10.2.2.5. ☑ The time limits for coverage of a child under the state plan;

10.2.2.6. ☑ The state's choice of health benefits coverage and other methods used for providing child health assistance, and

10.2.2.7. ☑ The sources of non-Federal funding used in the state plan.

10.2.3. ☑ An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

10.2.4. ☑ A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.

10.2.5. ☑ An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.

10.2.6. ☑ A description of any plans the state has for improving the availability of health insurance and health care for children.

10.2.7. ☑ Recommendations for improving the program under this Title.

10.2.8. ☑ Any other matters the state and the Secretary consider appropriate.

10.3. ☑ The state assures it will comply with future reporting requirements as they are developed.

10.4. ☑ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

ATTACHMENT #2
APPLICATION

ATTACHMENT #3
OUTREACH AND EDUCATION CONCEPTUAL PLAN

ATTACHMENT #4
SAMPLE REGIONAL PLANNING TEMPLATE

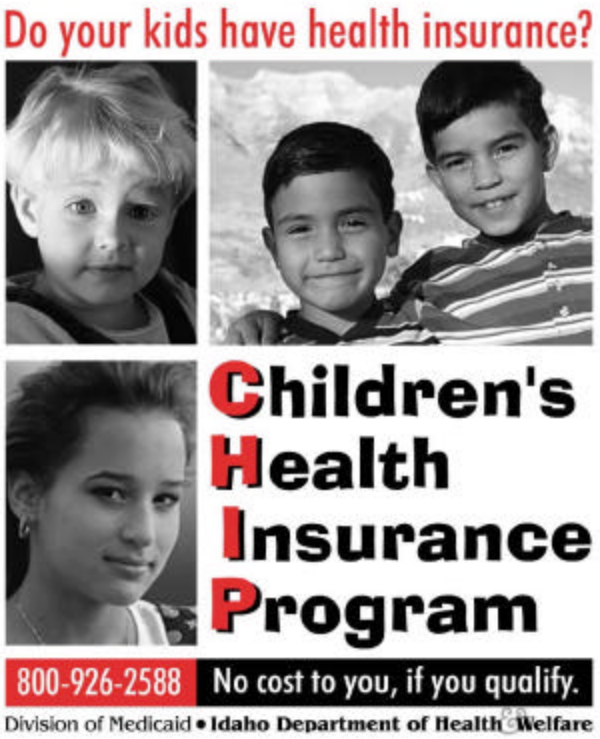
TEMPLATE FOR REGIONAL CHIP OUTREACH AND EDUCATION PLAN

Enclosed is the plan template for developing the CHIP Outreach and Education Plan for your region. To facilitate your planning efforts this document is designed to serve as the basis for your plan. You can replace directions with the names of partners, or decisions of the planning group. When you get done, you will have an operational plan and a document, which can be shared with community partners.

Plans are to be completed and submitted to Marnie Basom in the Division of Medicaid by *March 31, 2000*. Marnie can be contacted at (208) 364-1813 or basomma@mmis.state.id.us. The Healthy Connections Representative in your region has been assigned to work with you on plan development and implementation. We will schedule a telephone conference call in February to review this document and answer any questions.

The CHIP Outreach and Education Plan will help DHW make decisions around the appropriate aggregate funding needed for community outreach mini-contracts. In this document, you will provide us with a description of the activities you would like to fund with community mini contracts and the suggested contract amount. We will assemble this information from all regions to assist us in finalizing the total amount of funds available for distribution through this program.

IDAHO'S CHILDREN'S HEALTH INSURANCE PROGRAM



REGION 1
OUTREACH AND EDUCATION PLAN

KEY CONTACTS:

Regional Director's Name
Address
Phone Number
Email

Healthy Connections Regional Representative Name
Address
Phone Number
Email

DHW's Vision as it enters the new millennium is to:

Provide leadership for development and implementation of a sustainable, integrated health and human service system.

A key action step in achieving this vision is coordinated regional planning and service delivery of children's health services.

DHW's Vision for Idaho's Children's Health Insurance Program (CHIP):

To provide basic healthcare to uninsured children at or below 150% of the federal poverty level (34,805 children) through enrollment of children in CHIP (Title XIX and XXI).

Regional Outreach Plan Purpose:

The purpose of the regional plan is to provide a framework for the region to utilize in meeting the Department's CHIP goal through outreach and education activities. These activities are defined as follows:

Outreach: Activities targeted toward informing and motivating potentially eligible families to apply for health care coverage.

Education: The process of giving individuals and organizations which come into contact with low-income children information of health care coverage options.

COMMUNITY PARTNERS

Directions: This page should be used to identify key Department and community partners. These partners should be included in the planning activities for the region.

Essential Partners:

- Regional Management Team including Self-Reliance Program Manager, Family and Children's Services Program Manager, Developmental Disabilities Program Manager, Adult Mental Health Program Manager, and the Regional Medicaid Unit Program Manager
- Healthy Connections Representatives
- Community Resource Developer
- Regional Health District Representative, such as Physical Health Director, WIC Director, Others
- Head Start
- Culturally Diverse Representative (such as Migrant Councils or Representatives of Indian Reservations depending on location)
- Robert Wood Johnson Healthy Outcomes for Youth staff (where appropriate)
- Out-stationed Eligibility Workers – Federal Qualified Health Centers (FQHC)

Suggested Partners:

- Community Health Centers
- Family Practice Residency
- Hospital(s)
- Schools (nurses, principals, counselors)
- Child Care Providers
- Local Media Representatives
- Church health and social service programs
- Local Health Care Providers serving children (physicians, mid-level providers, nurses, office staff)
- Key nonprofits in your community who deliver services to the potential CHIP population

Directions: This page begins your actual plan description. Identify targeted groups, outreach strategy and expected results in the boxes provided.

Targeted Group	**Outreach Strategy**	**Expected Results**
Targeted groups are to be listed in this box. Groups chosen should consist of targets from the following list: ✓ *Schools* ✓ *Culturally Diverse Groups* ✓ *Head Start* ✓ *Childcare Providers* ✓ *Maternal & Child Health Programs, i.e. WIC* ✓ *Health Care Providers* ✓ *Child Advocacy Groups* ✓ *Regional DHW Program Participants* **Example:** ***Head Start***	*Your strategy for reaching each group should be described in this box. Strategies should directly link to a specific group and include which community partners will be involved and dates of implementation.* ***1. Hold training sessions for Head Start (HS) teachers and social workers in 2000. One time.*** ***2. Have SRS provide application assistance at HS registrations for 2000/01 school year. One time.*** *3.* ***Coordinate promotion program with the HS. health coordinators in 2000. Ongoing***	*Expected results for your efforts should be detailed in this box and. directly link to your targeted groups and strategies* ***Please put in this area in a brief description of what you would expect to achieve. For example, increased enrollment, more application sites, more application assistance, educated child advocates.***

PROPOSED COMMUNITY OUTREACH CONTRACTS

Directions: The purpose of the Community Outreach Contract program is to increase enrollment of hard-to-reach targeted groups in the Children's Health Insurance Program. Funds are for targeted outreach activities to such groups as Native Americans, Hispanics, Head Start, and WIC. Groups and activities should tie back to those groups and activities identified on the previous page of this document. Funds for Community Outreach Contracts will be available in May. Community Outreach contracts will range in size from $5,000 to $20,000 per contractor. Contracts are to go to community agencies and nonprofits and should not be utilized for in-house activities. Funds are not to be used for media activities. The Division of Medicaid will establish a standard application and reporting process. Applicants will have to meet the state's mandated procurement requirements but the "Scope of Work" requirements will be minimal to encourage ease of applications. The region will encourage and select the contractors based on the regional outreach plan. The contract will be between the region and the contractor with copies to the state. The Regional Director is responsible for monitoring the financial and programmatic aspects of each contract. We are recommending that the Regional Director assign the responsibility for programmatic monitoring to the Healthy Connections Representative.

To assist in designing the Community Outreach Program, we need information from your region on how you propose to award these funds. Please provide a brief description of activities you would like the Request for Proposal (RFP) to cover and the level of funding you anticipate would be necessary to fund the proposal. If you have a number of projects you are interested in funding which directly relate to the strategies described on the previous page(s) please list them all. We are requesting this information so that we can have an idea of the potential aggregate funding necessary to implement the Community Outreach Contract program across all regions. As of this writing, the Executive Oversight Committee for the CHIP program has not placed a limit on the total funds available for this program. Rather the Committee wanted to see your ideas and the total costs of these ideas before determining the final allocation available across the state or to any particular region.

POTENTIAL BUSINESS PARTNERS

Directions: List all potential business partners who might assist with outreach activities in your region, the desired assistance along with the contact person. For example: Mr. Smith's Bakery, provide gift certificates for drawings at health fairs, to be contacted by: Tanya Worker.

The following national organizations have made a commitment to CHIP at the national level but need to be contacted locally. You will be provided additional names of national commitments as we hear about them.

- Kmart
- March of Dimes

Potential Business Partner	Desired Action	Contact Person

CHIP REGIONAL STAFF RESOURCES AND STRUCTURE

Directions: Provide the names of the staff to be assigned to outreach/education activities and briefly describe what their assignments are.

VISTA Volunteer Request:

Regions have the opportunity to access an excellent resource at a minimal cost through the VISTA volunteer program. We are using the Immunize by 2 model as the basis for the design of the program. Individual volunteers are available to the region for one year. Assuming successful outcomes, regions could potentially have access to volunteers for up to four years. The VISTA agency recommends that each region consider two volunteers per region. If two volunteers are placed in the region, VISTA will pay 100% of the first volunteer's salary ($8,616) and Medicaid will pay for the second volunteer's salary. Requests from regions for only one volunteer, however, will be considered. Additional information on "The Role of VISTA Volunteer" and the "Americorps VISTA Fact Sheet" accompany this template as an attachment.

If you are interested in acquiring VISTA volunteers to assist with this project, you should make note of that request on this page. Indicate that you would like to use VISTA volunteers and describe the nature of the work and type of education/experience desirable for the volunteer to successfully fulfill the position requirements. Please specify what arrangements you have made for space, telephone, travel costs and computer availability. VISTA agency personnel have indicated that VISTA volunteers can be expected to share office space. Some regions with limited office space may also want to consider space sharing as a partnership activity in the plan.

Medicaid will pay for the VISTA volunteer's salary. Start-up and operating costs, i.e. computer, space, phone, and travel will be paid by the regional budget. The Healthy Connections Representative in field will be the day-to-day supervisor for the VISTA volunteer. The hiring process will be a joint activity between the Healthy Connections Representative and the Regional Director.

Types of activities a VISTA volunteer might engage in but are not limited to include:

- Presentations to civic groups, churches, schools, technical schools, and child care agencies
- Community canvassing
- Developing an application assistance project by identifying potential outreach sites and volunteers to assist applicants
- Developing and distributing parent information packets

CHIP REGIONAL STAFF RESOURCES AND STRUCTURE
(Continued)

Planned WIC Outreach Assistance:

The Division of Health will be establishing contracts with District Health Departments to perform outreach to populations served in their clinic settings such as WIC and Immunization which maybe eligible for children's health insurance coverage. The Regions should capitalize on the additional manpower provided through this collaborative effort with District Health Departments. The planning process provides the opportunity to include Districts in CHIP planning meetings to coordinate local outreach initiatives and share experiences about successful and not so successful approaches to enrolling children. Copies of the contracts with District Health will be provided to Regional Directors for the sake of providing information on activities the Districts are to perform.

The contracts are to further support the interest and work already being performed in the area of local service integration between Regions and Districts.

REGIONAL PLANNING COMMITTEE MEMBERS

Directions: Provide the name, title, who they represent, address, phone and email of all members of the planning committee. These individuals will be added to the CHIP list serve so that they receive regular updates on statewide activities as well as any CHIP mailings.

Name	Organization	Title	Address	Phone	Fax	E-mail

ATTACHMENT #5
TABLES SHOWING OUTREACH ACTIVITIES BY REGION

ATTACHMENT #6
STUDY OF DISENROLLMENT TRENDS

Children's Health Insurance Program Study

Since the beginning of the Children's Health Insurance Program (CHIP) in October 1997, EPICS reports a total of 8,523 children who received CHIP at sometime.

A statistically valid sample was randomly selected from those individuals. A sample size of 945 was chosen to allow a 95% confidence level with a +/- 2% precision.

Medicaid status was determined for the sample group. Fifty-five percent (55%) or 519 children are currently open in either CHIP or another Medicaid coverage group. The remaining 45% (426 children) are closed.

The study presents sample findings by current status, open coverage groups, reasons for closures, and ages of the sample children.

Figure 2: Percentages in Medicaid Coverage Groups

· A total of 519 individuals [sampled] are currently receiving Medicaid. Groups are defined as follows: Children's Health Insurance Program (CHIP), Title XIX Foster Care (FX), Aid to Dependent Children's Medicaid (MA/MU), Medicaid based on a disability (ME), and Medicaid for poverty level low income children (PW).

- Of the 158 open individuals in coverage groups other than CHIP, 142 (90%) moved without interruption from CHIP to their present group while 16 (10%) had a break in Medicaid coverage between CHIP and their current group.

- All individuals have only one (1) period of CHIP eligibility.

Closed CHIP

There are 351 children [sampled] who are closed from CHIP and have not received additional Medicaid coverage. Closure reasons are demonstrated in Figure 3 and 4 by percentages and numbers:

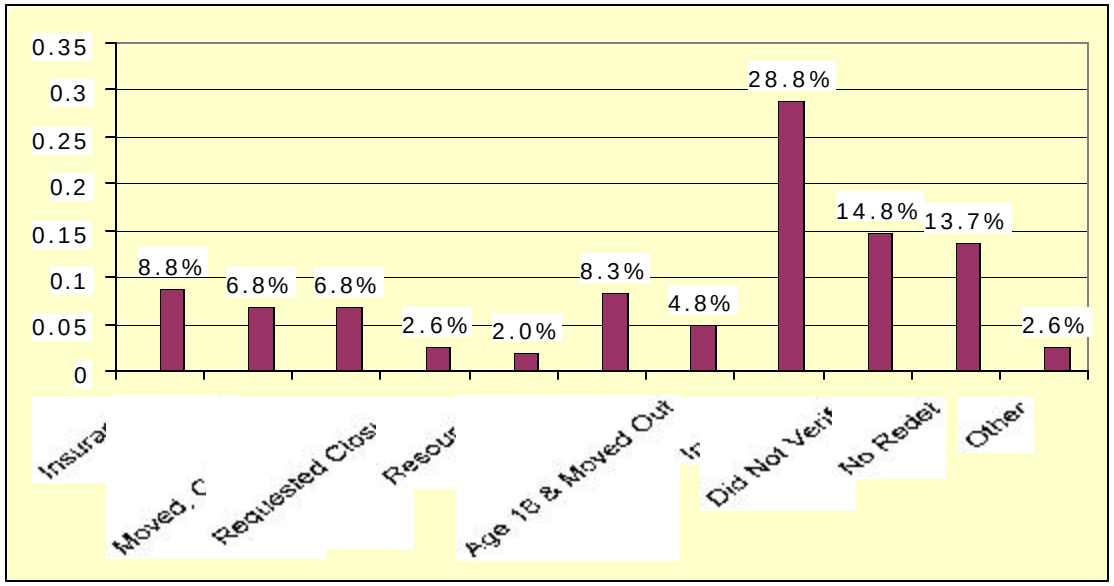
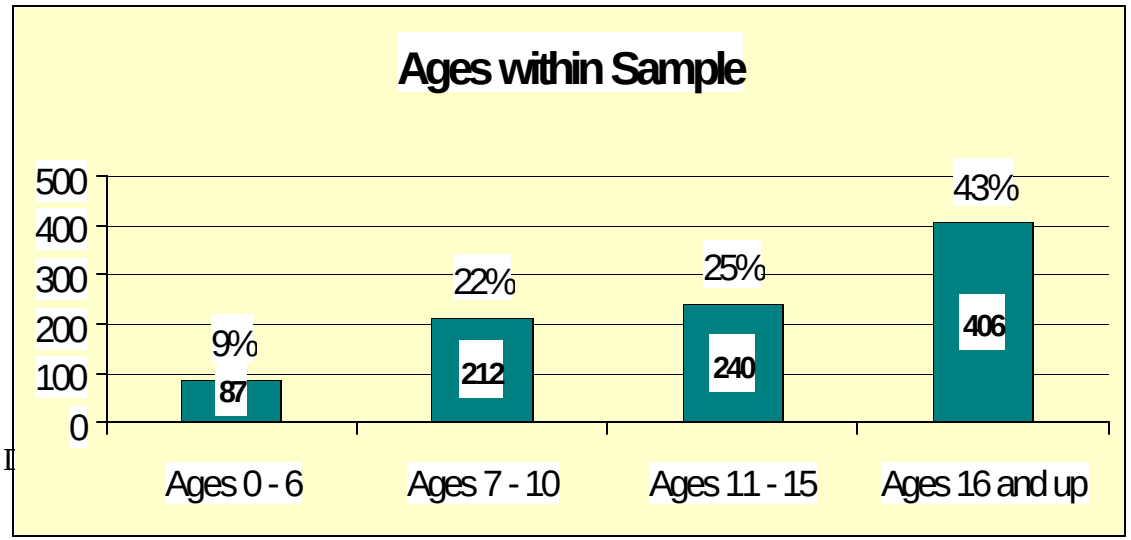


Figure 3: CHIP Closures by Reason and Percentage



Individuals who are currently closed but did receive Medicaid after their CHIP closure:

- There were 75 individuals, 8% of the sample, which received CHIP and then received Medicaid in another coverage group.
- Sixty-three (63) moved without Medicaid interruption from CHIP into the other group due to changes in family circumstances.
- Twelve (12) were not eligible for Medicaid for a period of time following CHIP closure then regained eligibility in another new group. CHIP closure reasons for the 12 are as follows: 6 were income closures, 3 were unable to locate, 2 were failure to provide verification, and 1 did not complete a redetermination.

Ages Within Sample

The year of birth was evaluated for the 945 individuals and ages were grouped. Figure 5 represents those groupings in number and percentages.

Other data of interest from sample:

414 (43.8%) received Medicaid in the month immediately prior to CHIP:
- 4 in FA/FX
- 89 in MA/MU
- 7 in ME
- 313 in PW
- 1 in RM

53 (5.6%) had multiple segments of CHIP that were interrupted:
- 32 were interrupted by a period of eligibility in another group
- 21 were interrupted by a period of Medicaid ineligibility

109 (11.5%) had a Medicaid coverage group interrupted with a period of CHIP eligibility. For example, a child receiving PW whose income went up moved to CHIP for a month or two. When income decreased, the child was returned to PW.

ATTACHMENT #7
ANALYSIS OF THE DIFFERENCE IN COST IN MEDICAID EXPANSION VS. STATE-ONLY

CHIP FINANCIAL IMPACT ANALYSIS

AUGUST 6, 1999

	TASK FORCE RECOMMENDATIONS		**LEAVE AS MEDICAID**	
	STATE FUND DOLLARS	***TOTAL DOLLARS***	***STATE FUND DOLLARS***	***TOTAL DOL***
AIM System Modifications	$322,700.00 one time cost	$322,700.00 one time cost	$34,000.00 one time cost	$136,000.00 or cost
EPICS System Modifications	$213,600.00 one time cost	$213,600.00 one time cost	$2,300.00 one time cost	$4,500.00 one cost
Develop software to track employer/individual subsidy program	$20,000.00 one time cost	$20,000.00 one time cost	$0.00	$0.00
Waiver Development	$700,000.00 one time cost	$700,00.00 one time cost	$0.00 $0.00	$0.00
Yearly independent review for waivers	$150,000.00 a year	$150,000.00 a year	$0.00	$0.00

CHIP FINANCIAL IMPACT ANALYSIS

AUGUST 6, 1999

	TASK FORCE RECOMMENDATIONS		LEAVE AS MEDICAID	
	STATE FUND DOLLARS	***TOTAL DOLLARS***	***STATE FUND DOLLARS***	***TOTAL DOL***
Scope of Coverage				
1. Benefit package				
a. orthodontia	$0.00	$0.00	$4,800.00 a year	$24,000.00 a y
b. lenses and frames	$0.00	$0.00	$4,500.00 a year	$22,800.00 a y
c. abortion services	$0.00	$0.00	$0.00	$0.00
d. contraceptives	$0.00	$0.00	$400.00 a year	$1,800.00 a ye
e. home & com based services	$0.00	$0.00	$6,400.00 a year	$32,300.00 a y
f. care coordination	$0.00	$0.00	$1,300.00 a year	$6,300.00 a ye
g. transportation to dr. visits	$0.00	$0.00	$300.00 a year	$1,600.00 a ye
h. full cost of organ transplants	$0.00	$0.00	$5,000.00 a year	$25,000.00 a y
i. other EPSDT services not defined in the State Plan	$0.00	$0.00		
j. in-pt sub abuse (assuming a 1% utilization rate)	$76,400.00 a year	$367,500.00 a year	$0.00	$0.00
2. Drug rebates	$0.00	$0.00 a year	($77,400.00) a year	($260,700.00) a
3. FMAP for Indian services	$31,100.00 a year	$31,100.00 a year	$0.00	$0.00
4. free vaccine program	$16,400.00 a year	$82,400.00 a year	$0.00	$0.00
Additional staffing requirements	$301,800.00 a year	$301,800.00 a year	$25,700.00 a year	$51,500.00 a y
Estimated administration costs in excess of the 10% cap	$320,000.00 a year	$320,000.00 a year	$160,000.00 a year	$320,000.00 a yea
TOTAL ONE TIME COSTS	***$1,256,400.00***	***$1,256,400.00***	***$36,300.00***	***$140,500.00***
TOTAL YEARLY ON-GOING COSTS	***$895,700.00***	***$1,253,200.00***	***$131,000.00***	***$224,600.00***
TOTAL FIRST YEAR COSTS	**$2,152,100.00**	**$2,509,600.00**	**$167,300.00**	**$365,100.0**

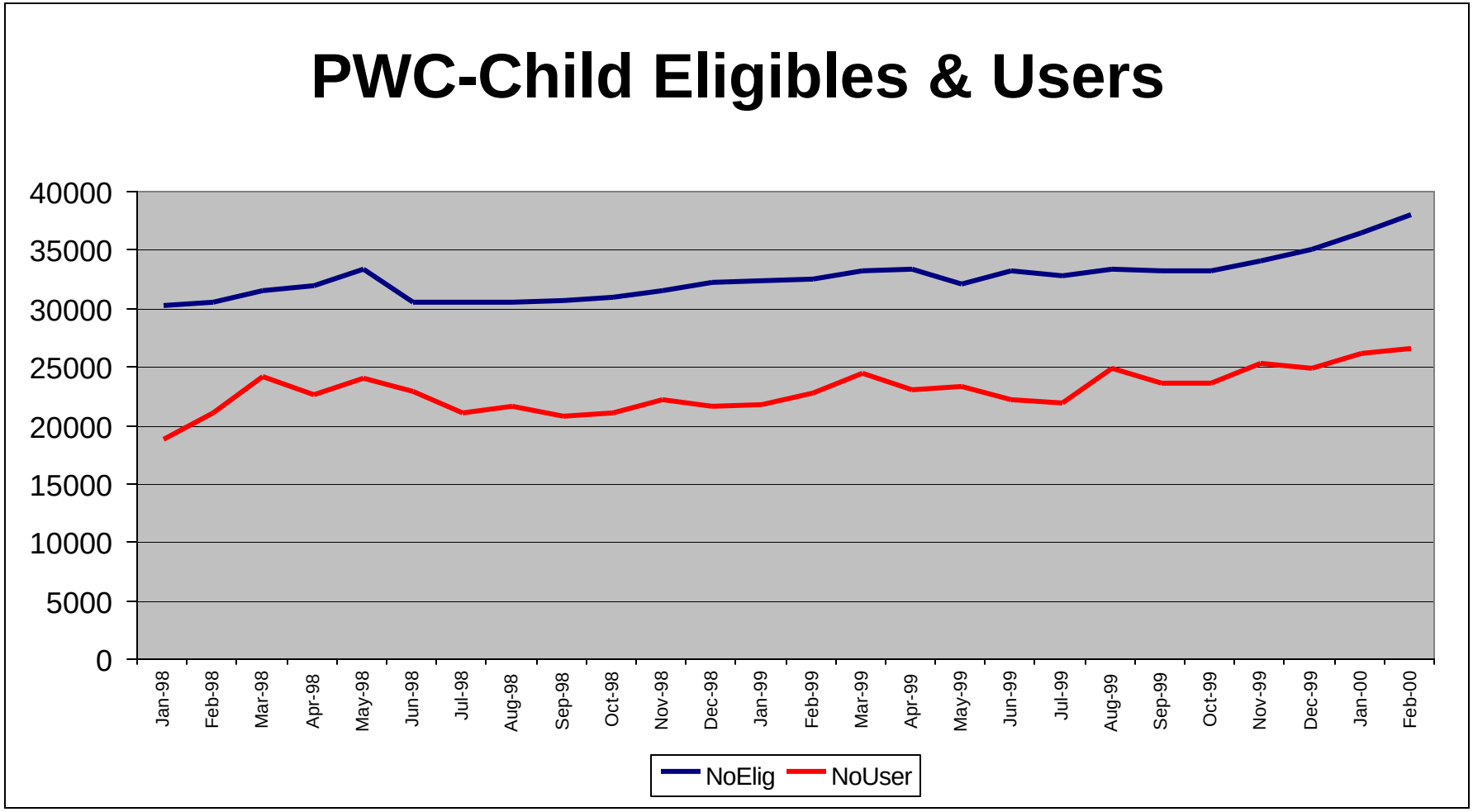
NOTE – ***All figures shown are estimates based on the best information available. In addition, while every effort was made to correctly ide all areas where additional costs or savings may be realized we may actually identify more or less as actual work progresses.***

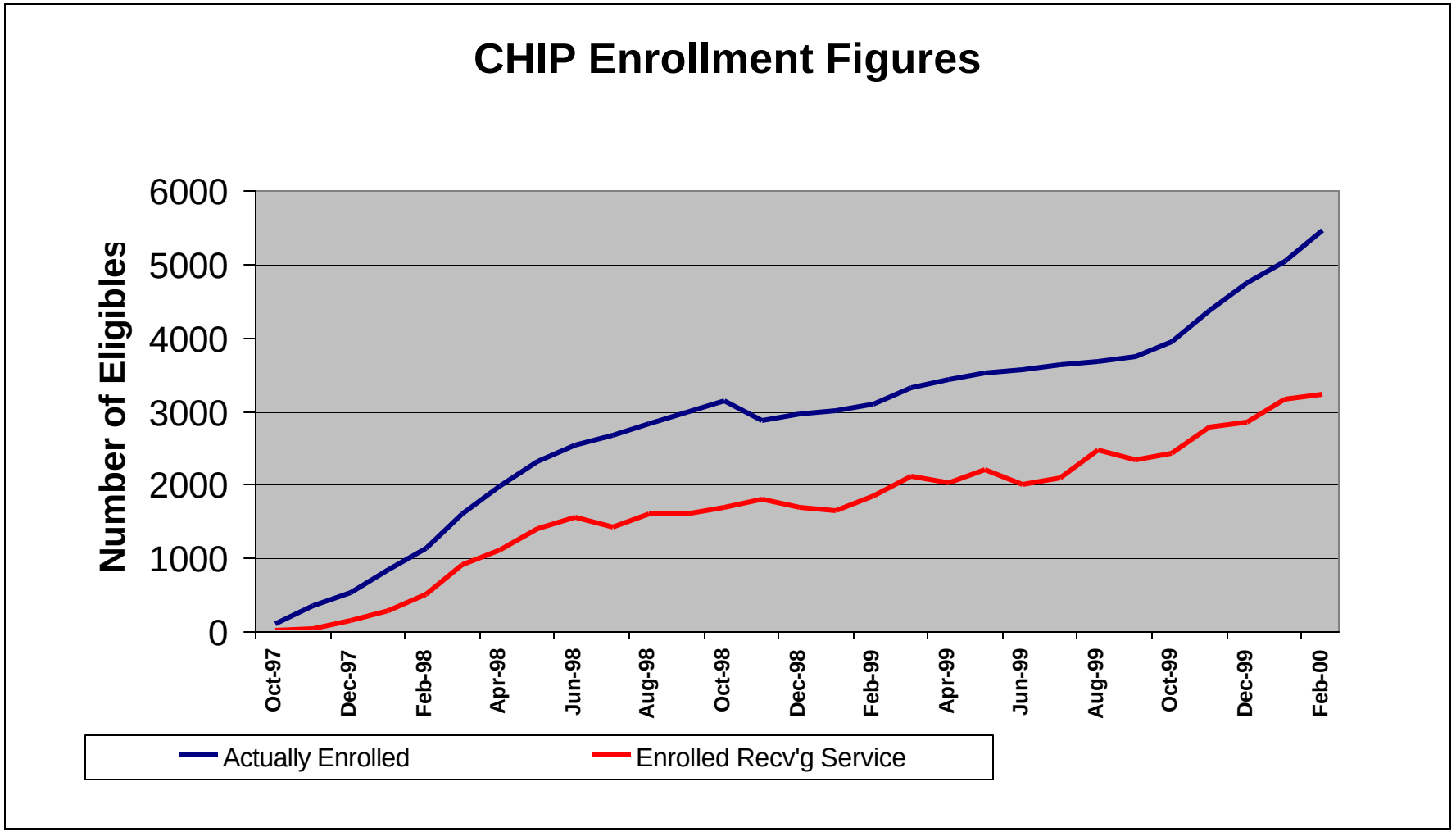
ATTACHMENT #8
SURVEY AND FINDINGS FROM HEALTHY CONNECTIONS CUSTOMER SURVEY

ATTACHMENT #9
DIRECTOR'S QUALITY IMPROVEMENT COMMITTEE MEMBERS

ATTACHMENT #10
SAMPLE WELFARE CUSTOMER SATISFACTION FORM

ATTACHMENT #11
COMPARISION OF ENROLLEES TO USERS OF MEDICAID SERVICES




CHIP Enrollment Figures
Number of Eligibles
6000
5000
4000
3000
2000
1000
0
Oct-97
Dec-97
Feb-98
Apr-98
Jun-98
Aug-98
Oct-98
Dec-98
Feb-99
Apr-99
Jun-99
Aug-99
Oct-99
Dec-99
Feb-00
Actually Enrolled
Enrolled Recv'g Service

ATTACHMENT #12
RESULTS OF FOCUS GROUPS ON NEW APPLICATION